



110TH CONGRESS
1ST SESSION

S. 1783

To provide 10 steps to transform health care in America.

IN THE SENATE OF THE UNITED STATES

JULY 12, 2007

Mr. ENZI introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide 10 steps to transform health care in America.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Ten Steps to Transform Health Care in America Act”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Purposes.
- Sec. 3. Definitions.

TITLE I—AFFORDABLE HEALTH INSURANCE COVERAGE

Subtitle A—Individual Coverage Responsibility and Availability of Core Plan Options

Sec. 101. Coverage responsibility.

- Sec. 102. Qualified core plans.
- Sec. 103. Qualified core compatible plans.
- Sec. 104. Certification.
- Sec. 105. State-based risk adjustments.
- Sec. 106. Relation to self-insured plans.
- Sec. 107. State flexibility and enforcement.

Subtitle B—Standard Deduction for Health Insurance and Related Provisions

- Sec. 121. Amendment of 1986 Code.
- Sec. 122. Standard deduction for health insurance.
- Sec. 123. Changes to existing tax preferences for medical coverage and costs for individuals eligible for standard deduction for health insurance.
- Sec. 124. Exclusion of standard deduction for health insurance from employment taxes.
- Sec. 125. Information reporting.
- Sec. 126. Reduction of phaseout for earned income credit.

Subtitle C—Health Insurance Tax Credit for the Purchase of Health Insurance

PART I—REFUNDABLE HEALTH INSURANCE TAX CREDIT

- Sec. 131. Refundable credit for health insurance coverage.
- Sec. 132. Advance payment of credit for purchasers of qualified health insurance.
- Sec. 133. Designation of health insurance status required by individuals on Federal income tax returns.

Subtitle D—Education and Outreach

- Sec. 141. Notice to taxpayers of availability of standard deduction for health insurance and refundable health insurance credit.
- Sec. 142. Optional enrollment and outreach.

TITLE II—INCREASING INSURANCE MARKET PORTABILITY AND AFFORDABILITY

Subtitle A—Merging and Improving Insurance Markets

- Sec. 201. Development of merged and improved State insurance market standards.
- Sec. 202. Modifications relating to self-funded group health plans.
- Sec. 203. Legislative proposals.
- Sec. 204. Enforcement.

Subtitle B—Reduction in Premium Variation and Health Status Discrimination

- Sec. 211. Development of standards for reduction in premium variation and health status discrimination among enrollees.
- Sec. 212. Enforcement.

Subtitle C—Enhanced Marketplace Pooling and Related Market Rating

PART I—ENHANCED MARKETPLACE POOLS

- Sec. 245. Rules governing enhanced marketplace pools.
- Sec. 246. Cooperation between Federal and State authorities.
- Sec. 247. Effective date and transitional and other rules.

PART II—MARKET RELIEF

- Sec. 251. Market relief.

PART III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

- Sec. 261. Health Insurance Standards Harmonization.

TITLE III—AFFORDABLE ACCESS TO HEALTH CARE FOR ALL AMERICANS

Subtitle A—Improving the Quality of Health Care by More Effectively Using Health Information Technology

- Sec. 300. Short title.

PART I—HEALTH INFORMATION TECHNOLOGY

SUBPART A—IMPROVING THE INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

- Sec. 301. Improving health care quality, safety, and efficiency.

SUBPART B—FACILITATING THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY

- Sec. 305. Facilitating the widespread adoption of interoperable health information technology.

SUBPART C—IMPROVING THE QUALITY OF HEALTH CARE

- Sec. 311. Consensus process for the adoption of quality measures for use in the nationwide interoperable health information technology infrastructure.

SUBPART D—PRIVACY AND SECURITY

- Sec. 321. Privacy and security.

SUBPART E—MISCELLANEOUS PROVISIONS

- Sec. 331. GAO study.
- Sec. 332. Health information technology resource center.
- Sec. 333. Facilitating the provision of telehealth services across State lines.

PART II—MAKING HEALTH CARE MORE ACCESSIBLE FOR ALL AMERICANS

- Sec. 341. Reauthorization of certain telehealth programs.
- Sec. 342. Quality improvement activities.
- Sec. 343. Sense of the senate regarding physician payments under medicare.

Subtitle B—Increasing Access to Physicians and Nurses

- Sec. 351. Reauthorization of programs and miscellaneous amendments.
- Sec. 352. Nurse workforce enhancement.
- Sec. 353. Visas for registered nurses.

Sec. 354. MedPAC study and report on the impact of payment caps for IME and GME.

Subtitle C—Increasing Access to Primary Care

Sec. 361. Reauthorization of the community health center programs.

Sec. 362. Reauthorization of loan repayment programs of the National Health Service Corps.

Sec. 363. Clarification of authority for convenient care clinics to participate in Medicaid and SCHIP.

Subtitle D—Rural Health Care

Sec. 371. Reauthorization of rural health care programs.

Subtitle E—Long Term Care

Sec. 381. Sense of the Senate.

Sec. 382. Living wills.

Sec. 383. Increasing Senior Choice and Access to Community-Based Long Term Care.

Subtitle F—Fair and Reliable Medical Justice

Sec. 391. Short title.

Sec. 392. Purposes.

Sec. 393. State demonstration programs to evaluate alternatives to current medical tort litigation.

1 **SEC. 2. PURPOSES.**

2 It is the purpose of this Act to—

3 (1) eliminate unfair tax treatment of health in-
4 surance thereby expanding choices, coverage, and
5 control over health care for all Americans;

6 (2) increase affordable options for working fam-
7 ilies to purchase health insurance through a stand-
8 ard tax deduction;

9 (3) ensure that affordable health insurance is
10 available to low-income individuals through the pro-
11 vision of a refundable, advanceable, assignable tax-
12 based subsidy;

(4) provide cross-State pooling to reduce health care costs and increase accessibility for small business owners, unions, associations, and their workers, members, and families;

(5) blend the individual and group health insurance markets to extend important Health Insurance Portability and Accountability Act portability protections to the individual market so that insurance security can better move with an individual from job to job;

(6) emphasize preventive health care and help individuals with chronic diseases better manage their health so America will finally have health care and not sick care;

(7) give individuals the choice to convert the value of Medicaid and SCHIP program benefits into private health insurance, putting Americans in control of their health care, not the Federal government;

(8) save lives and money by better coordinating health information technology to improve health care delivery;

(9) increase access to primary care in rural and frontier areas by helping future providers and nurses pay for their education, and giving seniors more op-

1 tions to receive care in their homes and commu-
2 nities; and

3 (10) decrease the sky-rocketing cost of health
4 care by restoring reliability in our medical justice
5 system through State-based solutions.

6 **SEC. 3. DEFINITIONS.**

7 Except as otherwise provided, in this Act:

8 (1) ADULT INDIVIDUAL.—The term “adult indi-
9 vidual” means an individual who—

10 (A) is—

11 (i) age 19 or older;

12 (ii) a resident of a State;

13 (iii)(I) a United States citizen; or

14 (II) an alien with permanent resi-
15 dence; and

16 (iv) not a dependent child; and

17 (B) in the case of an incarcerated indi-
18 vidual, such an individual who is incarcerated
19 for less than 1 month.

20 (2) ALIEN WITH PERMANENT RESIDENCE.—

21 The term “alien with permanent residence” has the
22 meaning given the term “qualified alien” in section
23 431 of the Personal Responsibility and Work Oppor-
24 tunity Reconciliation Act of 1996 (8 U.S.C. 1641).

(3) APPLICABLE STATE LAW.—The term “applicable State law” means the health insurance and related laws and regulations of a State.

(4) DEPENDENT CHILD.—The term “dependent child” has the meaning given the term “qualifying child” in section 152(c) of the Internal Revenue Code of 1986.

(5) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (6)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

(6) HEALTH MAINTENANCE ORGANIZATION.—The term “health maintenance organization” means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) an organization recognized under State law as a health maintenance organization; or

1 (C) a similar organization regulated under
2 State law for solvency in the same manner and
3 to the same extent as such a health mainte-
4 nance organization.

5 (7) QUALIFIED CORE COMPATIBLE PLAN.—The
6 term “qualified core compatible plan” means a com-
7 patible qualified core plan that meets the require-
8 ments of section 103.

9 (8) QUALIFIED CORE PLAN.—The term “quali-
10 fied core plan” means a qualified core plan described
11 under section 102.

12 (9) SECRETARY.—The term “Secretary” means
13 the Secretary of Health and Human Services, unless
14 expressly provided for otherwise in this Act.

15 (10) STATE.—The term “State” means each of
16 the several States of the United States, the District
17 of Columbia, the Commonwealth of Puerto Rico, the
18 Virgin Islands, American Samoa, Guam, the Com-
19 monwealth of the Northern Mariana Islands, and
20 other territories of the United States.

21 (11) STATE OF RESIDENCE.—The term “State
22 of residence”, with respect to an individual, means
23 the State in which the individual has primary resi-
24 dence.

TITLE I—AFFORDABLE HEALTH INSURANCE COVERAGE

Subtitle A—Individual Coverage Responsibility and Availability of Core Plan Options

SEC. 101. COVERAGE RESPONSIBILITY.

(a) INDIVIDUAL RESPONSIBILITY.—

(1) ADULT INDIVIDUALS.—Not later than 3 years after the date of enactment of this Act, each adult individual shall be encouraged to enroll in a qualified health plan that meets at least the requirements applied under section 224(d)(2) of the Internal Revenue Code of 1986.

(2) DEPENDENT CHILDREN.—Each adult individual enrolled in a health plan described in paragraph (1) shall have the responsibility to enroll (or provide evidence of enrollment of) each dependent child of the adult individual in such a health plan, or in a Federal or State governmental health coverage program for which such dependent child is eligible and which does not otherwise qualify as a health plan for purposes of paragraph (1).

(3) DETERMINATIONS OF ENROLLMENT.—An individual may demonstrate compliance with this subsection through—

(A) proof of enrollment of such individual and dependent children of such individual (if any) provided on the individual Federal tax return of the individual pursuant to regulation developed by the Secretary of the Treasury; or

(B) proof of such enrollment obtained pursuant to automatic enrollment as provided for in subsection (d).

(b) ELIGIBILITY FOR HEALTH INSURANCE ASSISTANCE.—Subject to this subsection and subsection (c), an individual and such dependent children of such individual who is enrolled in a health plan described in subsection (a)(1) shall be eligible to elect to receive—

(1) a standard Federal income tax deduction for health insurance; or

(2) an income-based tax credit subsidy.

(c) ENCOURAGEMENT.—Each State shall determine appropriate mechanisms, which may not include revocation or ineligibility for coverage under a qualified core plan or qualified core compatible plan, to encourage each adult individual to demonstrate coverage under a health plan described in subsection (a)(1) for such individual and compliance by such individual with the terms of paragraph (2) with respect to any dependent children of such individual.

(d) AUTOMATIC ENROLLMENT.—

1 (1) IN GENERAL.—Each State shall implement
2 mechanisms to automatically enroll an uninsured in-
3 dividual for health coverage if—

4 (A) such individual presents for treatment
5 to a licensed health care facility or provider
6 without health coverage under a health plan de-
7 scribed in subsection (a)(1) or otherwise under
8 a Federal or State government health coverage
9 program; or

10 (B) such individual designates the lack of
11 such coverage on the Federal tax return filed by
12 such individual.

13 (2) TYPE OF PLAN.—The mechanisms imple-
14 mented under paragraph (1) shall ensure that an in-
15 dividual is automatically enrolled, on a randomized
16 basis, in a qualified core plan offered in the State
17 of residence of the individual, or in any Federal or
18 State government health program if the individual is
19 eligible for such enrollment.

20 (3) COORDINATION.—The Secretary shall co-
21 ordinate with the Secretary of the Treasury and the
22 State insurance commissioners to develop procedures
23 for providing notification to relevant entities regard-
24 ing individuals who have indicated a lack of health
25 coverage on Federal tax returns, or who have pre-

1 sented to a licensed healthcare entity or provider as
 2 provided for in paragraph (1)(A).

3 **SEC. 102. QUALIFIED CORE PLANS.**

4 (a) OFFERING OF COVERAGE.—Each health insur-
 5 ance issuer offering health insurance coverage in a State
 6 shall offer at least one certified qualified core plan to indi-
 7 viduals residing in that State and shall market such plans
 8 in a manner that is substantially similar to the manner
 9 in which such issuer markets coverage or other health in-
 10 surance plans such issuer offers in the State. If a State
 11 determines that a health insurance issuer is failing to offer
 12 (or market) such coverage in the State as provided for
 13 in this subsection, the State shall not license such issuer
 14 to offer health insurance coverage in such State (or revoke
 15 any existing license of such issuer effective upon the expi-
 16 ration of the subsequent plan year).

17 (b) CERTIFICATION.—Each State shall certify a plan
 18 as a qualified core plan if the plan meets the requirements
 19 of subsection (c).

20 (c) REQUIREMENTS.—

21 (1) IN GENERAL.—To be certified as a qualified
 22 core plan, the plan shall—

23 (A) provide coverage for benefits, items, or
 24 services as required by the State;

(B) provide coverage for basic preventive items or services, as the State may define such items or services, in accordance with paragraph (2);

(C) provide coverage for medical self-management and for items or services needed for such self-management, as the State may define such items or services;

(D) require payment of the applicable standard premium for coverage under the plan (as determined in accordance with subsection (d));

(E) adhere to the cost sharing limitations prescribed under subsection (e);

(F) provide for the submission of data as required under subsection (f); and

(G) comply with any other requirements applicable under State law.

(2) BASIC PREVENTIVE ITEMS OR SERVICES.—

The basic preventive items or services for which coverage shall be provided under a qualified core plan shall be determined—

(A) pursuant to applicable State law; or

(B) if no such State law is in effect, based on standards and guidelines issued by the Sec-

1 retary (in consultation with the National Asso-
2 ciation of Insurance Commissioners).

3 (d) STANDARD PREMIUM AMOUNT.—

4 (1) IN GENERAL.—Except as provided for in
5 this subsection, the standard premium for coverage
6 under a qualified core plan for the initial plan year
7 following the date on which the requirement under
8 section 101(a) applies shall be—

9 (A) \$2,500 for individual coverage; and

10 (B) \$5,000 for family coverage.

11 (2) CPI ADJUSTMENT.—Each of the amounts
12 provided for under paragraph (1) shall be annually
13 increased, beginning in the second plan year fol-
14 lowing the date on which the requirement under sec-
15 tion 101(a) applies, by the percentage increase in
16 the Consumer Price Index for the previous plan
17 year. As used in the preceding sentence, the term
18 “Consumer Price Index” means the last Consumer
19 Price Index for all-urban consumers published by
20 the Department of Labor.

21 (e) COST SHARING LIMITATIONS.—

22 (1) IN GENERAL.—A qualified core plan shall
23 comply with the following cost sharing limitations:

1 (A) DEDUCTIBLES.—The amount of any
2 deductible shall not exceed \$2,500 for a plan
3 year.

4 (B) COPAYMENTS.—The amount of any
5 copayments shall not exceed 20 percent.

6 (C) ANNUAL LIMITS.—The annual limit on
7 cost sharing payment shall not exceed \$5,000.

8 (2) ADJUSTMENT FOR INFLATION.—Each of
9 the amounts provided for under paragraph (1) shall
10 be annually increased, beginning in the second plan
11 year following the date on which the requirement
12 under section 101(a) applies, by the percentage in-
13 crease in the Consumer Price Index for the previous
14 plan year. As used in the preceding sentence, the
15 term “Consumer Price Index” means the last Con-
16 sumer Price Index for all-urban consumers published
17 by the Department of Labor.

18 (3) NO APPLICATION OF COST SHARING FOR
19 PREVENTION AND MEDICAL SELF-MANAGEMENT.—A
20 qualified core plan may not impose cost sharing re-
21 quirements on—

22 (A) basic preventive items or services; or

23 (B) medical self-management items or
24 services.

1 (4) DECERTIFICATION.—A State shall suspend
2 or revoke the certification of any qualified core plan
3 if the State determines that any policy or procedure
4 implemented with respect to the plan has the effect,
5 or likely effect, of materially altering the overall level
6 of cost sharing obligations that may be required of
7 enrollees under the plan. Notwithstanding the pre-
8 vious sentence, an individual covered under such a
9 plan may continue coverage under such plan through
10 the expiration of the current plan year, or if such ex-
11 piration date is less than 6 months from the date of
12 decertification, for an additional plan year.

13 (f) ACTUARIAL VALUE DATA AND APPLICATION.—

14 (1) IN GENERAL.—A health insurance issuer
15 shall annually submit to the State insurance com-
16 missioner and the Secretary a determination as to
17 the aggregate actuarial value of each qualified core
18 plan and qualified core compatible plan offered by
19 the issuer in the State. In developing and submitting
20 such data, the issuer shall utilize actuarial standards
21 established by the National Association of Insurance
22 Commissioners.

23 (2) PUBLICATION AND SUBMISSION TO SEC-
24 RETARY.—A State insurance commissioner shall—

(A) compile all data received under paragraph (1) with respect to the State;

(B) publish such data in a manner that enables individuals in the State to use such data in making health insurance decisions; and

(C) submit such data in report form to the Secretary.

(3) USE OF DATA.—

(A) IN GENERAL.—The Secretary shall, using the data provided under paragraph (2)(C), annually publish a national standard qualified core plan actuarial value (referred to as the “National actuarial value”).

(B) QUALIFIED CORE COMPATIBLE PLANS.—For provisions relating to the use of the National actuarial value with respect to qualified core compatible plans, see section 103(c)(1)(D).

(4) SUSPENSION OR REVOCATION OF CERTIFICATION.—The State shall suspend or revoke the certification of any qualified core plan or qualified core compatible plan, upon the expiration of the subsequent plan year, for which a health insurance issuer has failed to submit data as required under paragraph (1).

1 (g) APPLICATION TO STATE LAW.—Unless provided
2 otherwise in this Act, nothing in this Act shall be con-
3 strued to preempt State laws relating to health insurance,
4 including State benefit mandate laws, consumer protection
5 requirements, solvency and related fiscal requirements for
6 qualified core plans.

7 (h) MARKET AVAILABILITY STUDY.—

8 (1) ASSESSMENT.—Prior to the implementation
9 of regulations relating to the certification of quali-
10 fied core plans under this Act, the Secretary, in con-
11 sultation with the National Association of Insurance
12 Commissioners, shall conduct an assessment of the
13 effect of the application of the National actuarial
14 value as a requirement for certification of qualified
15 core compatible plans under section 103(c)(1)(D), in-
16 cluding the effect of such application on the afford-
17 ability of qualified core compatible plans, the entry
18 of health insurance issuers into the qualified core
19 plan and qualified core compatible plan market, and
20 on health insurance market access, affordability, and
21 competition.

22 (2) REPORT.—The Secretary shall submit to
23 Congress a report concerning the results of the as-
24 sessment conducted under paragraph (1).

1 **SEC. 103. QUALIFIED CORE COMPATIBLE PLANS.**

2 (a) OFFERING OF COVERAGE.—A health insurance
3 issuer offering health insurance coverage in a State may
4 offer one or more certified qualified core compatible plans
5 to individuals residing in that State.

6 (b) CERTIFICATION.—Each State shall certify a plan
7 as a qualified core compatible plan if the plan meets the
8 requirements of subsection (c).

9 (c) REQUIREMENTS.—

10 (1) IN GENERAL.—To be certified as a qualified
11 core compatible plan, the plan shall—

12 (A) provide coverage for benefits, items, or
13 services as required by the State;

14 (B) provide coverage for basic preventive
15 items or services;

16 (C) provide coverage for medical self-man-
17 agement and for items or services needed for
18 such self-management, as the State may define
19 such items or services;

20 (D) have an actuarial value that is not less
21 than the national standard actuarial value de-
22 termined under section 102(f)(3)(A); and

23 (E) comply with any other requirements
24 imposed by the State.

25 (2) BASIC PREVENTIVE ITEMS OR SERVICES.—

26 The basic preventive items or services for which cov-

1 erage shall be provided under a qualified core com-
2 patible plan shall be determined in the same manner
3 as provided for under section 102(c)(2).

4 (3) PREMIUMS AND COST SHARING.—Except as
5 provided in this Act, premium and cost sharing re-
6 quirements applicable to qualified core compatible
7 plans shall be determined in accordance with appli-
8 cable State law.

9 (d) APPLICATION OF STATE LAW.—Unless specifi-
10 cally provided otherwise in this Act, nothing in this Act
11 shall be construed to preempt State laws relating to health
12 insurance, including State benefit mandate laws, consumer
13 protection requirements, and solvency and related fiscal
14 requirements for qualified core compatible plans.

15 **SEC. 104. CERTIFICATION.**

16 (a) IN GENERAL.—A health insurance issuer shall
17 submit an application to the State insurance commissioner
18 for the certification of a health plan as a qualified core
19 plan or a qualified core compatible plan for purposes of
20 offering coverage under such plan in the State.

21 (b) REGULATIONS.—The Secretary, in consultation
22 with the National Association of Insurance Commis-
23 sioners, shall promulgate regulations that provide stand-
24 ards and procedures for the certification, and suspension
25 or revocation of the certification, of qualified core plans

1 and qualified core compatible plans to ensure that such
 2 plans comply, and maintain such compliance, with the re-
 3 quirements and standards applicable to such plans under
 4 this title.

5 **SEC. 105. STATE-BASED RISK ADJUSTMENTS.**

6 (a) IN GENERAL.—The State shall seek to lessen
 7 such material risk selection as may occur among qualified
 8 core plans, qualified compatible core plans, and other li-
 9 censed health insurance products (not including self-in-
 10 sured plans) through the application of State risk adjust-
 11 ment requirements that are certified by the Secretary as
 12 meeting standards established by the Secretary (in con-
 13 sultation with the National Association of Insurance Com-
 14 missioners).

15 (b) ASSESSMENT AND REPORT.—

16 (1) IN GENERAL.—Prior to the development of
 17 standards under subsection (a), the Secretary, in
 18 consultation with the National Association of Insur-
 19 ance Commissioners, shall conduct an assessment
 20 of—

21 (A) the degree of the actual or actuarially
 22 anticipated material adverse selection among
 23 qualified core plans, qualified core compatible
 24 plans, and other insured health plans; and

1 (B) the comparative efficiency of State risk
2 adjustment requirement options to minimize
3 such hazards.

4 (2) REPORT.—The Secretary shall submit a re-
5 port to Congress concerning the results of the as-
6 sessment conducted under paragraph (1). Such re-
7 port shall include such recommendations as the Sec-
8 retary may include for additional or future legisla-
9 tion to adjust the standards developed under sub-
10 section (a) if the Secretary determines that such leg-
11 islation is reasonably necessary to provide for the ef-
12 fective application of the requirements of subsection
13 (a).

14 **SEC. 106. RELATION TO SELF-INSURED PLANS.**

15 (a) IN GENERAL.—An individual who is enrolled in
16 health care coverage under a self-insured health plan (as
17 defined for purposes of the Employee Retirement Income
18 Security Act of 1974 (29 U.S.C. 1001 et seq.)) shall be
19 deemed to be in compliance with the requirements of sec-
20 tion 101(a), and other than as expressly provided for oth-
21 erwise in this Act, current law with respect to such plans
22 shall remain in effect.

23 (b) DEMONSTRATION OF ACTUARIAL VALUE.—The
24 health insurance issuer of a plan described in subsection
25 (a), shall submit to the Secretary of Labor evidence dem-

1 onstrating that the coverage alternative involved meets the
2 requirements of such subsection.

3 (c) CERTIFICATION PROCESS.—Certification, or sus-
4 pension or revocation of certification, of health plans
5 under this section shall be administered by the Secretary
6 of Labor in consultation with the State insurance commis-
7 sioner.

8 **SEC. 107. STATE FLEXIBILITY AND ENFORCEMENT.**

9 (a) IN GENERAL.—

10 (1) STATE AUTHORITY.—Subject to subsection
11 (d), each State shall require that health insurance
12 issuers that issue, sell, renew, or offer health insur-
13 ance coverage in the State meet the requirements es-
14 tablished under this subtitle with respect to such
15 issuers and with respect to qualified core plans and
16 qualified core compatible plans.

17 (2) FAILURE TO IMPLEMENT REQUIRE-
18 MENTS.—In the case of a State that fails to sub-
19 stantially implement and enforce the requirements
20 set forth in this subtitle with respect to health insur-
21 ance issuers in the State, the Secretary shall imple-
22 ment and enforce the requirements of this subtitle
23 under subsection (c) insofar as they relate to the
24 issuance, sale, renewal, and offering of qualified core

1 plans and qualified core compatible plans in such
2 State.

3 (b) PROCEDURE.—

4 (1) PRESUMPTION.—

5 (A) IN GENERAL.—Subject to the suc-
6 ceeding provisions of this subsection, a State is
7 presumed to be implementing and enforcing
8 this subtitle if, by not later than the date that
9 is 6 months after the date of enactment of this
10 Act, the chief executive officer of the State—

11 (i) notifies the Secretary that the
12 State has enacted or intends to enact (by
13 not later than January 1, 2009, or July 1,
14 2009 in the case of a State described in
15 subparagraph (B)(ii)) any necessary legis-
16 lation to provide for the implementation
17 and enforcement of such subtitle; and

18 (ii) provides the Secretary with such
19 information as the Secretary may require
20 to review the legislation and its implemen-
21 tation (or proposed implementation) under
22 this subsection.

23 (B) DELAY PERMITTED FOR CERTAIN
24 STATES.—

1 (i) EFFECT OF DELAY.—In the case
2 of a State described in clause (ii) that pro-
3 vides notice under subparagraph (A)(i), for
4 the presumption to continue on and after
5 July 1, 2009, the chief executive officer of
6 the State by April 1, 2009—

7 (I) must notify the Secretary
8 that the State has enacted any nec-
9 essary legislation to provide for the
10 implementation and enforcement of
11 this subtitle as of July 1, 2009; and

12 (II) must provide the Secretary
13 with such information as the Sec-
14 retary may require to review the legis-
15 lation and its implementation (or pro-
16 posed implementation) under this sub-
17 section.

18 (ii) STATES DESCRIBED.—A State de-
19 scribed in this clause is a State that has
20 a legislature that does not meet within the
21 12-month period beginning on the date of
22 enactment of this Act.

23 (C) CONTINUED APPLICATION.—In order
24 for a State to continue to be presumed to be
25 implementing and enforcing the requirements of

1 this subtitle, the State shall provide the Sec-
2 retary every 3 years with information described
3 in subparagraph (A)(ii) or (B)(i)(II) (as the
4 case may be).

5 (2) NOTICE.—If the Secretary finds, after re-
6 view of information provided under paragraph (1)
7 and in consultation with the chief executive officer of
8 the State and the insurance commissioner of the
9 State, that the State is not implementing and en-
10 forcing the requirements of this subtitle, the Sec-
11 retary—

12 (A) shall notify the State of—

13 (i) such preliminary determination,
14 and

15 (ii) the consequences under paragraph
16 (3) of a failure to carry out such imple-
17 mentation and enforcement; and

18 (B) shall permit the State a reasonable op-
19 portunity in which to modify State law in a
20 manner so that may be acceptable implementa-
21 tion and enforcement.

22 (3) FINAL DETERMINATION.—If, after pro-
23 viding notice and opportunity under paragraph (2),
24 the Secretary finds that the State is not imple-
25 menting or enforcing the requirements of this sub-

1 title, the Secretary shall notify the State of such fact
 2 and that the Secretary shall be responsible for en-
 3 forcing such requirements in the State.

4 (4) FUTURE ADOPTION OF MECHANISMS.—If a
 5 State, after the Secretary makes a notification de-
 6 scribed in paragraph (3), submits the notice and in-
 7 formation described in paragraph (1), unless the
 8 Secretary makes a finding described in paragraph
 9 (3) within the 90-day period beginning on the date
 10 of submission of the notice and information, the
 11 mechanism shall be considered to be an acceptable
 12 alternative mechanism for purposes of this section,
 13 effective 90 days after the end of such period, sub-
 14 ject to the second sentence of paragraph (1).

15 (c) SECRETARIAL ENFORCEMENT AUTHORITY.—

16 (1) LIMITATION.—The provisions of this sub-
 17 section shall apply with respect to the enforcement
 18 of a provision (or provisions) of this subtitle only—

19 (A) as provided under subsection (a)(2);

20 and

21 (B) with respect to health insurance
 22 issuers and qualified core plans and qualified
 23 core compatible plans.

24 (2) IMPOSITION OF PENALTIES.—In the cases
 25 described in paragraph (1):

1 (A) IN GENERAL.—Subject to the suc-
2 ceeding provisions of this subsection, any health
3 insurance issuer that fails to comply with a pro-
4 vision of this subtitle applicable to such issuer
5 with respect to a qualified core plan or qualified
6 core compatible plan is subject to a civil money
7 penalty under this subsection.

8 (B) AMOUNT OF PENALTY.—

9 (i) IN GENERAL.—The maximum
10 amount of penalty imposed under this
11 paragraph is \$100 for each day for each
12 individual with respect to which such a
13 failure occurs.

14 (ii) CONSIDERATIONS IN IMPOSI-
15 TION.—In determining the amount of any
16 penalty to be assessed under this para-
17 graph, the Secretary shall take into ac-
18 count the previous record of compliance of
19 the issuer being assessed with the applica-
20 ble provisions of this subtitle and the grav-
21 ity of the violation.

22 (iii) LIMITATIONS.—

23 (I) PENALTY NOT TO APPLY
24 WHERE FAILURE NOT DISCOVERED
25 EXERCISING REASONABLE DILI-

1 GENCE.—No civil money penalty shall
2 be imposed under this paragraph on
3 any failure during any period for
4 which it is established to the satisfac-
5 tion of the Secretary that none of the
6 entities against whom the penalty
7 would be imposed knew, or exercising
8 reasonable diligence would have
9 known, that such failure existed.

10 (II) PENALTY NOT TO APPLY TO
11 FAILURES CORRECTED WITHIN 30
12 DAYS.—No civil money penalty shall
13 be imposed under this paragraph on
14 any failure if such failure was due to
15 reasonable cause and not to willful ne-
16 glect, and such failure is corrected
17 during the 30-day period beginning on
18 the first day any of the entities
19 against whom the penalty would be
20 imposed knew, or exercising reason-
21 able diligence would have known, that
22 such failure existed.

23 (C) ADMINISTRATIVE REVIEW.—

24 (i) OPPORTUNITY FOR HEARING.—
25 The entity assessed shall be afforded an

1 opportunity for hearing by the Secretary
2 upon request made within 30 days after
3 the date of the issuance of a notice of as-
4 sessment. In such hearing the decision
5 shall be made on the record pursuant to
6 section 554 of title 5, United States Code.
7 If no hearing is requested, the assessment
8 shall constitute a final and unappealable
9 order.

10 (ii) HEARING PROCEDURE.—If a
11 hearing is requested, the initial agency de-
12 cision shall be made by an administrative
13 law judge, and such decision shall become
14 the final order unless the Secretary modi-
15 fies or vacates the decision. Notice of in-
16 tent to modify or vacate the decision of the
17 administrative law judge shall be issued to
18 the parties within 30 days after the date of
19 the decision of the judge. A final order
20 which takes effect under this paragraph
21 shall be subject to review only as provided
22 under subparagraph (D).

23 (D) JUDICIAL REVIEW.—

24 (i) FILING OF ACTION FOR REVIEW.—
25 Any entity against whom an order impos-

ing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of the district court concerning such review shall be subject to

1 appeal as provided in chapter 83 of title 28
2 of such Code.

3 (E) FAILURE TO PAY ASSESSMENT; MAIN-
4 TENANCE OF ACTION.—

5 (i) FAILURE TO PAY ASSESSMENT.—If
6 any entity fails to pay an assessment after
7 it has become a final and unappealable
8 order, or after the court has entered final
9 judgment in favor of the Secretary, the
10 Secretary shall refer the matter to the At-
11 torney General who shall recover the
12 amount assessed by action in the appro-
13 priate United States district court.

14 (ii) NONREVIEWABILITY.—In such ac-
15 tion the validity and appropriateness of the
16 final order imposing the penalty shall not
17 be subject to review.

18 (F) PAYMENT OF PENALTIES.—Except as
19 otherwise provided, penalties collected under
20 this paragraph shall be paid to the Secretary
21 (or other officer) imposing the penalty and shall
22 be available without appropriation and until ex-
23 pended for the purpose of enforcing the provi-
24 sions with respect to which the penalty was im-
25 posed.

(d) PREEMPTION.—

(1) IN GENERAL.—Subject to subsection (b), nothing in this subtitle shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this subtitle.

(2) RULES OF CONSTRUCTION.—Except as otherwise provided for in this Act, nothing in this subtitle shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

Subtitle B—Standard Deduction for Health Insurance and Re- lated Provisions

SEC. 121. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

1 **SEC. 122. STANDARD DEDUCTION FOR HEALTH INSUR-**
2 **ANCE.**

3 (a) IN GENERAL.—Part VII of subchapter B of chap-
4 ter 1 (relating to additional itemized deductions for indi-
5 viduals) is amended by redesignating section 224 as sec-
6 tion 225 and by inserting after section 223 the following
7 new section:

8 **“SEC. 224. STANDARD DEDUCTION FOR HEALTH INSUR-**
9 **ANCE.**

10 “(a) DEDUCTION ALLOWED.—In the case of an indi-
11 vidual, there shall be allowed as a deduction to the tax-
12 payer for the taxable year the standard deduction for
13 health insurance.

14 “(b) STANDARD DEDUCTION FOR HEALTH INSUR-
15 ANCE.—For purposes of this section—

16 “(1) IN GENERAL.—The term ‘standard deduc-
17 tion for health insurance’ means the sum of the
18 amounts determined under paragraph (2) with re-
19 spect to each individual for whom the taxpayer is al-
20 lowed a deduction under section 151 (relating to al-
21 lowance of deduction for personal exemptions) for
22 the taxable year.

23 “(2) ALLOWANCE FOR EACH INDIVIDUAL.—The
24 amount determined under this paragraph with re-
25 spect to any individual is the sum of the monthly

1 limitations for months during the taxable year that
2 the individual is an eligible individual.

3 “(3) MONTHLY LIMITATION.—

4 “(A) IN GENERAL.—The monthly limita-
5 tion for any month is $\frac{1}{12}$ of \$7,500.

6 “(B) COST-OF-LIVING ADJUSTMENT.—

7 “(i) IN GENERAL.—In the case of tax-
8 able years beginning in calendar years
9 after the first calendar year to which this
10 section applies, the \$7,500 amount under
11 subparagraph (A) shall be increased by an
12 amount equal to—

13 “(I) such dollar amount, multi-
14 plied by

15 “(II) the cost-of-living adjust-
16 ment determined under section 1(f)(3)
17 for the calendar year in which such
18 taxable year begins, determined by
19 substituting ‘the calendar year pre-
20 ceding the first calendar year to which
21 section 224 applies’ for ‘calendar year
22 1992’ in subparagraph (B) thereof.

23 “(ii) ROUNDING.—If any increase
24 under clause (i) is not a multiple of \$50,

1 such increase shall be rounded to the near-
2 est multiple of \$50.

3 “(c) LIMITATIONS AND SPECIAL RULES RELATING
4 TO STANDARD DEDUCTION.—For purposes of this sec-
5 tion—

6 “(1) ONLY 2 ELIGIBLE INDIVIDUALS TAKEN
7 INTO ACCOUNT.—A taxpayer shall not take into ac-
8 count more than 2 eligible individuals for any month
9 in computing the standard deduction for health in-
10 surance for purposes of subsection (a).

11 “(2) SPECIAL RULE FOR MARRIED INDIVIDUALS
12 FILING SEPARATELY.—In the case of a married indi-
13 vidual who files a separate return for the taxable
14 year, the deduction allowed under subsection (a)
15 shall be equal to one-half of the amount which would
16 otherwise be determined under subsection (a) if such
17 individual filed a joint return for the taxable year.

18 “(3) DENIAL OF DEDUCTION TO DEPEND-
19 ENTS.—No deduction shall be allowed under this
20 section to any individual with respect to whom a de-
21 duction under section 151 is allowable to another
22 taxpayer for a taxable year beginning in the cal-
23 endar year in which such individual’s taxable year
24 begins.

1 “(4) COORDINATION WITH OTHER HEALTH TAX
2 INCENTIVES.—

3 “(A) DENIAL OF DEDUCTION IF HEALTH
4 INSURANCE COSTS CREDIT ALLOWED.—No de-
5 duction shall be allowed under this section to
6 any taxpayer if a credit is allowed to the tax-
7 payer under section 35 or 36 for the taxable
8 year.

9 “(B) REDUCTION FOR INSURANCE PUR-
10 CHASED WITH MSA OR HSA FUNDS.—The
11 amount allowed as a deduction under subsection
12 (a) for the taxable year shall be reduced by the
13 aggregate amount—

14 “(i) paid during the taxable year from
15 an Archer MSA to which section
16 220(d)(2)(B)(ii) (other than subelause (II)
17 thereof) applies, and

18 “(ii) paid during the taxable year
19 from a health savings account to which
20 section 223(d)(2)(C) (other than clause (ii)
21 thereof) applies.

22 “(5) SPECIAL RULE FOR DIVORCED PARENTS,
23 ETC.—Notwithstanding subsection (b)(1), an indi-
24 vidual who is a child may be taken into account on
25 the return of the parent other than the parent for

1 whom a deduction with respect to the child is al-
 2 lowed under section 151 for a taxable year beginning
 3 in a calendar year if—

4 “(A) the parent for whom the deduction
 5 under section 151 is allowed for a taxable year
 6 beginning in such calendar year signs a written
 7 declaration (in such manner and form as the
 8 Secretary may by regulations prescribe) that
 9 such parent will not claim the deduction allow-
 10 able under this section with respect to the child
 11 for taxable years beginning in such calendar
 12 year, and

13 “(B) the parent for whom the deduction
 14 under section 151 is not allowed attaches such
 15 written declaration to the parent’s return for
 16 the taxable year beginning in such calendar
 17 year.

18 “(d) OTHER DEFINITIONS.—For purposes of this
 19 section—

20 “(1) ELIGIBLE INDIVIDUAL.—

21 “(A) IN GENERAL.—The term ‘eligible in-
 22 dividual’ means, with respect to any month, an
 23 individual who is covered under a qualified
 24 health plan as of the 1st day of such month.

1 “(B) COVERAGE UNDER MEDICARE, MED-
2 ICAID, OR SCHIP AND GRANDFATHERED EM-
3 PLOYER COVERAGE.—The term ‘eligible indi-
4 vidual’ shall not include any individual who for
5 any month is—

6 “(i) entitled to benefits under part A
7 of title XVIII of the Social Security Act or
8 enrolled under part B of such title,

9 “(ii) enrolled in the program under
10 title XIX or XXI of such Act (other than
11 under section 1928 of such Act), or

12 “(iii) receiving benefits (other than
13 under continuation coverage under section
14 4980B) which constitute medical care from
15 an employer—

16 “(I) from whom such individual
17 is separated from service at the time
18 of receipt of such benefits, and

19 “(II) after such separation, if
20 such benefits began before January 1,
21 2010,

22 unless such individual is also covered by a
23 qualified health plan as of the 1st day of such
24 month.

1 “(C) IDENTIFICATION REQUIREMENTS.—

2 The term ‘eligible individual’ shall not include
3 any individual for any month unless the policy
4 number associated with coverage under the
5 qualified health plan and the TIN of each eligi-
6 ble individual covered under such coverage for
7 such month is included on the return for the
8 taxable year in which such month occurs.

9 “(2) QUALIFIED HEALTH PLAN.—

10 “(A) IN GENERAL.—The term ‘qualified
11 health plan’ means a health plan (within the
12 meaning of section 223(c)(2), without regard to
13 subparagraph (A)(i) thereof) which, under regu-
14 lations prescribed by the Secretary, meets the
15 following requirements:

16 “(i) The plan has a reasonable annual
17 or lifetime benefit maximum.

18 “(ii) The plan has coverage for inpa-
19 tient and outpatient care, emergency bene-
20 fits, and physician care.

21 “(iii) No pre-existing condition limita-
22 tions are imposed with respect to any eligi-
23 ble individual.

1 “(iv) The plan has coverage which
2 meaningfully limits individual economic ex-
3 posure to extraordinary medical expenses

4 “(B) EXCLUSION OF CERTAIN PLANS.—
5 The term ‘qualified health plan’ does not in-
6 clude—

7 “(i) a health plan if substantially all
8 of its coverage is coverage described in sec-
9 tion 223(c)(1)(B);

10 “(ii) any program or benefits referred
11 to in clause (i), (ii), or (iii) of paragraph
12 (1)(B), and

13 “(iii) a medicare supplemental policy
14 (as defined in section 1882 of the Social
15 Security Act).

16 “(e) REGULATIONS.—The Secretary may prescribe
17 such regulations as may be necessary to carry out this
18 section.”.

19 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL
20 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
21 of section 62 is amended by inserting before the last sen-
22 tence at the end the following new paragraph:

23 “(22) STANDARD DEDUCTION FOR HEALTH IN-
24 SURANCE.—The deduction allowed by section 224.”.

1 (c) ELECTION TO TAKE HEALTH INSURANCE COSTS
 2 CREDIT.—Section 35(g) (relating to special rules for cred-
 3 it for health insurance costs of eligible individuals) is
 4 amended by redesignating paragraph (9) as paragraph
 5 (10) and by inserting after paragraph (8) the following
 6 new paragraph:

7 “(9) ELECTION NOT TO CLAIM CREDIT.—This
 8 section shall not apply to a taxpayer for any taxable
 9 year if such taxpayer elects to have this section not
 10 apply for such taxable year.”.

11 (d) CLERICAL AMENDMENT.—The table of sections
 12 for part VII of subchapter B of chapter 1 is amended by
 13 striking the item relating to section 224 and adding at
 14 the end the following new items:

“Sec. 224. Standard deduction for health insurance.

“Sec. 225. Cross reference.”.

15 (e) EFFECTIVE DATE.—The amendments made by
 16 this section shall apply to taxable years beginning on or
 17 after the first day of the first calendar year in which oc-
 18 curs the first date on which the requirement of section
 19 101(a) of this Act applies.

1 **SEC. 123. CHANGES TO EXISTING TAX PREFERENCES FOR**
2 **MEDICAL COVERAGE AND COSTS FOR INDIVIDUALS ELIGIBLE FOR STANDARD DEDUC-**
3 **TION FOR HEALTH INSURANCE.**
4

5 (a) DEDUCTION FOR MEDICAL, DENTAL, ETC., EX-
6 PENSES.—Section 213 (relating to medical, dental, etc.,
7 expenses) is amended by adding at the end the following
8 new subsection:

9 “(f) TERMINATION OF DEDUCTION FOR INDIVIDUALS
10 NOT COVERED BY MEDICARE, MEDICAID, SCHIP, OR
11 GRANDFATHERED EMPLOYER PLANS.—

12 “(1) IN GENERAL.—Except as provided in para-
13 graph (2), no deduction shall be allowed under sub-
14 section (a) for any taxable year with respect to
15 which a deduction under section 224 is allowable.

16 “(2) EXCEPTION FOR INDIVIDUALS COVERED
17 BY MEDICARE, MEDICAID, SCHIP, OR GRAND-
18 FATHERED EMPLOYER PLANS.—Paragraph (1) shall
19 not apply to an individual for any taxable year if
20 such individual is not an eligible individual (as de-
21 fined in section 224(d)(1)) for any month during
22 such taxable year by reason of coverage described in
23 section 224(d)(1)(B).”.

24 (b) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER
25 TO ACCIDENT AND HEALTH PLANS.—

1 (1) IN GENERAL.—Section 106 (relating to con-
 2 tributions by employer to accident and health plans)
 3 is amended by adding at the end the following new
 4 subsection:

5 “(f) SUBSECTIONS (a) AND (c) APPLY ONLY TO INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR
 6 GRANDFATHERED EMPLOYER PLANS.—

8 “(1) IN GENERAL.—Except as provided in para-
 9 graph (2), subsections (a) and (c) shall not apply for
 10 any taxable year with respect to which a deduction
 11 under section 224 is allowable.

12 “(2) EXCEPTION FOR INDIVIDUALS COVERED
 13 BY MEDICARE, MEDICAID, SCHIP, OR GRAND-
 14 FATHERED EMPLOYER PLANS.—Paragraph (1) shall
 15 not apply to an individual for any taxable year if
 16 such individual is not an eligible individual (as de-
 17 fined in section 224(d)(1)) for any month during
 18 such taxable year by reason of coverage described in
 19 section 224(d)(1)(B).”.

20 (2) CONFORMING AMENDMENTS.—

21 (A) Section 106(b)(1) is amended—

22 (i) by inserting “gross income does
 23 not include” before “amounts contrib-
 24 uted”, and

(ii) by striking “shall be treated as employer-provided coverage for medical expenses under an accident or health plan”.

(B) Section 106(d)(1) is amended—

(i) by inserting “gross income does not include” before “amounts contributed”, and

(ii) by striking “shall be treated as employer-provided coverage for medical expenses under an accident or health plan”.

(c) AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

“(j) SECTION ONLY TO APPLY TO INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRANDFATHERED EMPLOYER PLANS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), subsection (b) shall not apply for any taxable year with respect to which a deduction under section 224 is allowable.

“(2) EXCEPTION FOR INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRAND-

1 FATHERED EMPLOYER PLANS.—Paragraph (1) shall
2 not apply to an individual for any taxable year if
3 such individual is not an eligible individual (as de-
4 fined in section 224(d)(1)) for any month during
5 such taxable year by reason of coverage described in
6 section 224(d)(1)(B).”.

7 (d) TERMINATION OF DEDUCTION FOR HEALTH IN-
8 SURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—
9 Subsection (l) of section 162 (relating to special rules for
10 health insurance costs of self-employed individuals) is
11 amended by adding at the end the following new para-
12 graph:

13 “(6) TERMINATION.—This subsection shall not
14 apply to taxable years with respect to which a deduc-
15 tion under section 224 is allowable.”.

16 (e) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning on or
18 after the first day of the first calendar year in which oc-
19 curs the first date on which the requirement of section
20 101(a) of this Act applies.

1 **SEC. 124. EXCLUSION OF STANDARD DEDUCTION FOR**
 2 **HEALTH INSURANCE FROM EMPLOYMENT**
 3 **TAXES.**

4 (a) IN GENERAL.—Chapter 25 (relating to general
 5 provisions relating to employment taxes) is amended by
 6 adding at the end the following new section:

7 **“SEC. 3511. EXCLUSION OF STANDARD DEDUCTION FROM**
 8 **EMPLOYMENT TAXES.**

9 “(a) IN GENERAL.—For purposes of chapters 21, 22,
 10 and 23, each of the following amounts for any period (de-
 11 termined without regard to this section) shall be reduced
 12 by the portion of the standard deduction for health insur-
 13 ance (as defined in section 224) allocable to the period:

14 “(1) The amount of wages determined under
 15 section 3121(a).

16 “(2) The amount of compensation determined
 17 under section 3231(e).

18 “(3) The amount of wages determined under
 19 section 3306(b).

20 “(b) DETERMINATION OF STANDARD DEDUCTION
 21 ALLOCABLE TO A PERIOD.—For purposes of subsection
 22 (a)—

23 “(1) IN GENERAL.—The determination of the
 24 portion of the standard deduction for health insur-
 25 ance allocable to a period shall be made on the basis

1 of a qualified certificate of eligible coverage fur-
 2 nished by the employee to the employer.

3 “(2) QUALIFIED CERTIFICATE OF ELIGIBLE
 4 COVERAGE.—The term ‘qualified certificate of eligi-
 5 ble coverage’ means a statement of eligibility for the
 6 deduction allowable under section 224 which con-
 7 tains such information, is in such form, and is pro-
 8 vided at such times, as the Secretary may prescribe.

9 “(3) ONLY 1 CERTIFICATE IN EFFECT AT A
 10 TIME.—Except as provided by the Secretary, an em-
 11 ployee may have only 1 qualified certificate of eligi-
 12 ble coverage in effect for any period.

13 “(4) ELECTION.—An employee may elect not to
 14 have this section apply for any period for purposes
 15 of chapter 21 or 22.

16 “(c) RECONCILIATION OF ERRONEOUS PAYMENTS
 17 TO BE MADE AT EMPLOYEE LEVEL.—

18 “(1) IN GENERAL.—If the application of this
 19 subsection results in an incorrect amount being
 20 treated as wages or compensation for purposes of
 21 chapter 21, 22, or 23, whichever is applicable, with
 22 respect to any employee for 1 or more periods end-
 23 ing within a taxable year of the employee—

24 “(A) in the case of an aggregate overpay-
 25 ment of the taxes imposed by any such chapter

for all such periods, there shall be allowed as a credit against the tax imposed by chapter 1 for such taxable year on such employee an amount equal to the amount of such overpayment, and

“(B) in the case of an aggregate underpayment of the taxes imposed by any such chapter for all such periods, the employee shall be liable for payment of the entire amount of such underpayment.

“(2) CREDITS TREATED AS REFUNDABLE.—For purposes of this title, any credit determined under paragraph (1)(A) or subsection (d)(2) shall be treated as if it were a credit allowed under subpart C of part IV of subchapter A of chapter 1.

“(3) RULES FOR REPORTING AND COLLECTION OF TAX.—Any tax required to be paid by an employee under paragraph (1)(B) shall be included with the employee’s return of Federal income tax for the taxable year.

“(4) SECRETARIAL AUTHORITY.—The Secretary shall prescribe such rules as may be necessary to carry out the provisions of this subsection.

“(d) PHASE IN.—

“(1) IN GENERAL.—In the case of the first 3 calendar years to which this section applies, sub-

1 section (a) shall apply to wages and compensation of
 2 an employee only for purposes of section 3101,
 3 3201, 3211, or 3301, whichever is applicable.

4 “(2) CREDIT.—In the case of any taxable year
 5 beginning in a calendar year to which paragraph (1)
 6 applies, there shall be allowed as a credit against the
 7 tax imposed by chapter 1 for such taxable year on
 8 an employee an amount equal to the excess of—

9 “(A) the tax imposed under section 3111
 10 or 3231, whichever is applicable, on the wages
 11 of the employee for the part of such calendar
 12 year in such taxable year, over

13 “(B) the tax which would have been im-
 14 posed under section 3111 or 3231, whichever is
 15 applicable, on the wages of the employee for the
 16 part of such calendar year in such taxable year
 17 if subsection (a) had applied for purposes of
 18 section 3111 or 3231.”.

19 (b) SELF-EMPLOYMENT INCOME.—Section 1402 (de-
 20 fining net earnings from self-employment) is amended by
 21 adding at the end the following:

22 “(1) STANDARD DEDUCTION FOR HEALTH INSUR-
 23 ANCE.—For purposes of this chapter—

24 “(1) IN GENERAL.—The self-employment in-
 25 come of a taxpayer for any period (determined with-

out regard to this subsection) shall be reduced by the excess (if any) of—

“(A) the portion of the standard deduction for health insurance (as defined in section 224) allocable to the period, over

“(B) the amount of any reduction in wages or compensation for such period under section 3511.

“(2) DETERMINATION OF STANDARD DEDUCTION ALLOCABLE TO A PERIOD.—For purposes of paragraph (1), the portion of the standard deduction allocable to any period shall be determined in a manner similar to the manner under section 3511.”.

(c) CONFORMING AMENDMENTS.—

(1) Section 3121(a)(2) is amended by inserting “which is excludable from gross income under section 105 or 106” after “such payment”).

(2) Subsection (a) of section 209 of the Social Security Act (42 U.S.C. 409) is amended by striking “or” at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting “; or”, and by inserting after paragraph (19) the following new paragraph:

“(20) any amount excluded from wages under section 3511(a) of the Internal Revenue Code of

1 1986 (relating to exclusion of standard deduction
2 from employment taxes).”.

3 (3) Section 1324(b)(2) of title 31, United
4 States Code, is amended by inserting “, or the credit
5 under section 3511(c)(2) of such Code” before the
6 period at the end.

7 (4) Section 209(k)(2) of the Social Security Act
8 is amended by redesignating subparagraphs (C) and
9 (D) as subparagraphs (D) and (E), respectively, and
10 by inserting after subparagraph (B) the following
11 new subparagraph:

12 “(C) by disregarding the exclusion from wages
13 in subsection (a)(20),”.

14 (5) The table of sections for chapter 25 is
15 amended by adding at the end the following new
16 item:

“Sec. 3511. Exclusion of standard deduction from employment taxes.”.

17 (d) EFFECTIVE DATES.—

18 (1) IN GENERAL.—Except as provided in para-
19 graph (2), the amendments made by this section
20 shall apply to remuneration paid or accrued for peri-
21 ods on or after the first day of the first calendar
22 year in which occurs the first date on which the re-
23 quirement of section 101(a) of this Act applies.

24 (2) RECONCILIATION AND SELF-EMPLOYED.—
25 Sections 3511(c) and (d)(2) of the Internal Revenue

Code of 1986 (as added by subsection (a)), and the amendments made by subsection (b), shall apply to taxable years beginning on or after the first day described in paragraph (1).

SEC. 125. INFORMATION REPORTING.

(a) HEALTH PLAN PROVIDERS.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by adding at the end the following new section:

“SEC. 6050W. COVERAGE UNDER QUALIFIED HEALTH PLAN.

“(a) IN GENERAL.—Every person providing coverage under a qualified health plan (as defined in section 224(d)(2)) during a calendar year shall, on or before January 31 of the succeeding year, make a return described in subsection (b) with respect to each individual who is covered by such person under a qualified health plan for any month during the calendar year.

“(b) RETURN.—A return is described in this subsection if such return—

“(1) is in such form as the Secretary prescribes, and

“(2) contains—

“(A) the name of the person providing coverage under the qualified health plan,

1 “(B) the name, address, and TIN of the
2 individual covered by the plan,

3 “(C) if such individual is the owner of the
4 policy under which such plan is provided, the
5 name, address, and TIN of each other indi-
6 vidual covered by such policy and the relation-
7 ship of each such individual to such owner, and

8 “(D) the specific months of the year for
9 which each individual referred to in subpara-
10 graph (B) is, as of the first day of each such
11 month, covered by such plan.

12 “(c) STATEMENT TO BE FURNISHED WITH RE-
13 SPECT TO WHOM INFORMATION IS REQUIRED.—Every
14 person required to make a return under subsection (a)
15 shall furnish to each individual whose name is required
16 to be set forth in such return under subsection (b)(2)(A)
17 a written statement showing—

18 “(1) the name, address, and phone number of
19 the information contact of the person required to
20 make such return, and

21 “(2) the information described in subsection
22 (b)(2).

23 The written statement required under the preceding sen-
24 tence shall be furnished on or before January 31 of the

1 year following the calendar year for which the return
2 under subsection (a) was required to be made.”.

3 (b) EMPLOYERS.—Subsection (a) of section 6051 (re-
4 lating to requirement for employers to provide W-2 infor-
5 mation) is amended by striking “and” at the end of para-
6 graph (12), by striking the period at the end of paragraph
7 (13) and inserting “, and”, and by inserting after para-
8 graph (13) the following new paragraph:

9 “(14) the value (determined under section
10 4980B(f)(4)) of employer-provided coverage for each
11 month under an accident or health plan and the cat-
12 egory of such coverage for purposes of section
13 6116.”.

14 (c) APPLICATION TO RETIREES.—Subsection (a) of
15 section 6051 is amended by adding at the end the fol-
16 lowing: “In the case of a retiree, this section shall (to the
17 extent established by the Secretary by regulation) apply
18 only with respect to paragraph (14).”.

19 (d) ASSESSABLE PENALTIES.—

20 (1) Subparagraph (B) of section 6724(d)(1) of
21 such Code (relating to definitions) is amended by re-
22 designating clauses (xv) through (xx) as clauses (xvi)
23 through (xxi), respectively, and by inserting after
24 clause (xi) the following new clause:

1 (B) by striking “21.06” and inserting
2 “15”,

3 (2) in subparagraph (B)—

4 (A) by striking “15.98” and inserting
5 “15”, and

6 (B) by striking “20.22” and inserting
7 “15”, and

8 (3) in subparagraph (C)—

9 (A) by striking “15.98” and inserting
10 “15”, and

11 (B) by striking “17.68” and inserting
12 “15”.

13 (b) EFFECTIVE DATE.—The amendments made by
14 subsection (a) shall apply to taxable years beginning on
15 or after the first day of the first calendar year in which
16 occurs the first date on which the requirement of section
17 101(a) of this Act applies.

1 **Subtitle C—Health Insurance Tax**
 2 **Credit for the Purchase of**
 3 **Health Insurance**

4 **PART I—REFUNDABLE HEALTH INSURANCE TAX**
 5 **CREDIT**

6 **SEC. 131. REFUNDABLE CREDIT FOR HEALTH INSURANCE**
 7 **COVERAGE.**

8 (a) IN GENERAL.—Subpart C of part IV of sub-
 9 chapter A of chapter 1 of the Internal Revenue Code of
 10 1986 (relating to refundable credits) is amended by redes-
 11 ignating section 36 as section 37 and by inserting after
 12 section 35 the following new section:

13 **“SEC. 36. REFUNDABLE CREDIT FOR HEALTH INSURANCE**
 14 **COVERAGE.**

15 “(a) IN GENERAL.—In the case of an individual,
 16 there shall be allowed as a credit against the tax imposed
 17 by this subtitle an amount equal to the health insurance
 18 credit amount of the taxpayer for the taxable year.

19 “(b) HEALTH INSURANCE CREDIT AMOUNT.—For
 20 purposes of this section—

21 “(1) IN GENERAL.—The term ‘health insurance
 22 credit amount’ means, with respect to any taxable
 23 year, the lesser of—

24 “(A) the sum of the amounts determined
 25 under paragraph (2) with respect to each indi-

vidual for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year, or

“(B) an amount equal to twice the individual annual limit in effect for the taxable year under paragraph (3).

“(2) ALLOWANCE FOR EACH INDIVIDUAL.—The amount determined under this paragraph with respect to any individual is the sum of the monthly limitations for coverage months of the individual occurring during the taxable year.

“(3) MONTHLY LIMITATION.—

“(A) IN GENERAL.—The monthly limitation for any month is $1/12$ of the individual annual limit for the taxable year.

“(B) INDIVIDUAL ANNUAL LIMIT.—The individual annual limit is \$2,500.

“(C) COST-OF-LIVING ADJUSTMENT.—

“(i) IN GENERAL.—In the case of taxable years beginning in calendar years after the first calendar year to which this section applies, the \$2,500 amount under subparagraph (B) shall be increased by an amount equal to—

1 “(I) such dollar amount, multi-
2 plied by

3 “(II) the cost-of-living adjust-
4 ment determined under section 1(f)(3)
5 for the calendar year in which such
6 taxable year begins, determined by
7 substituting ‘the calendar year pre-
8 ceding the first calendar year to which
9 section 36 applies’ for ‘calendar year
10 1992’ in subparagraph (B) thereof.

11 “(ii) ROUNDING.—If any increase
12 under clause (i) is not a multiple of \$50,
13 such increase shall be rounded to the near-
14 est multiple of \$50.

15 “(4) COVERAGE MONTH.—For purposes of this
16 subsection—

17 “(A) IN GENERAL.—The term ‘coverage
18 month’ means, with respect to an individual,
19 any month if—

20 “(i) as of the first day of such month
21 such individual is covered by qualified
22 health insurance, and

23 “(ii) the premium for coverage under
24 such insurance for such month is paid by
25 the taxpayer.

1 “(B) EXCEPTION FOR EMPLOYER-SUB-
2 SIDIZED COVERAGE.—If an individual is eligible
3 to participate for any month in any subsidized
4 health plan maintained by any employer of the
5 taxpayer or the taxpayer’s spouse, such month
6 shall not be treated as a coverage month with
7 respect to the individual.

8 “(C) EXCEPTION FOR CERTAIN GOVERN-
9 MENTAL COVERAGE.—The term ‘coverage
10 month’ shall not include any month with re-
11 spect to an individual if for such month the in-
12 dividual is—

13 “(i) entitled to benefits under part A
14 of title XVIII of the Social Security Act or
15 enrolled under part B of such title,

16 “(ii) enrolled in the program under
17 title XIX or XXI of such Act (other than
18 under section 1928 of such Act), unless
19 the individual has elected under such pro-
20 gram to be enrolled for coverage under
21 qualified health insurance for the month in
22 lieu of coverage under such program, or

23 “(iii) is entitled to any benefit
24 under—

1 “(I) chapter 55 of title 10,
2 United States Code,

3 “(II) chapter 17 of title 38,
4 United States Code, or

5 “(III) any medical care program
6 under the Indian Health Care Im-
7 provement Act.

8 “(D) PRISONERS.—The term ‘coverage
9 month’ shall not include any month with re-
10 spect to an individual if for such month the in-
11 dividual is imprisoned under Federal, State, or
12 local authority for a period of at least 1 month.

13 “(E) INSUFFICIENT PRESENCE IN UNITED
14 STATES.—The term ‘coverage month’ shall not
15 include any month during a taxable year with
16 respect to an individual if such individual is
17 present in the United States on fewer than 183
18 days during such year (determined in accord-
19 ance with section 7701(b)(7)).

20 “(c) LIMITATIONS.—

21 “(1) PHASEOUT OF CREDIT BASED ON AD-
22 JUSTED GROSS INCOME.—

23 “(A) IN GENERAL.—If the taxpayer’s
24 modified adjusted gross income exceeds the ap-
25 plicable threshold amount for any taxable year,

the amount allowed as a credit under subsection (a) (determined without regard to this paragraph) shall be reduced (but not below zero) by the amount which bears the same ratio to such amount as such excess bears to an amount equal to the difference between the applicable threshold amount and 300 percent of the applicable threshold amount.

“(B) APPLICABLE THRESHOLD AMOUNT.—For purposes of subparagraph (A), the applicable threshold amount for a taxable year shall be determined in accordance with the following table:

“If the number of personal exemptions is:	The applicable threshold amount is:
1	\$10,210
2	\$13,690
3	\$17,170
4 or more	\$20,650

“(C) PERSONAL EXEMPTIONS.—For purposes of subparagraph (B), the number of personal exemptions of a taxpayer is equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

“(D) COST-OF-LIVING ADJUSTMENT.—

1 “(i) IN GENERAL.—In the case of tax-
2 able years beginning in calendar years
3 after the first calendar year to which this
4 section applies, each of the dollar amounts
5 in the table under subparagraph (B) shall
6 be increased by an amount equal to—

7 “(I) such dollar amount, multi-
8 plied by

9 “(II) the cost-of-living adjust-
10 ment determined under section 1(f)(3)
11 for the calendar year in which such
12 taxable year begins, determined by
13 substituting ‘the calendar year pre-
14 ceding the first calendar year to which
15 section 36 applies’ for ‘calendar year
16 1992’ in subparagraph (B) thereof.

17 “(ii) ROUNDING.—If any increase
18 under clause (i) is not a multiple of \$50,
19 such increase shall be rounded to the near-
20 est multiple of \$50.

21 “(E) MODIFIED ADJUSTED GROSS IN-
22 COME.—The term ‘modified adjusted gross in-
23 come’ means adjusted gross income deter-
24 mined—

1 “(i) without regard to sections 911,
2 931, and 933, and

3 “(ii) after application of sections 86,
4 135, 137, 219, 221, and 469.

5 “(2) IDENTIFICATION REQUIREMENTS.—No
6 credit shall be allowed under subsection (a) for any
7 coverage month with respect to an individual unless
8 the policy number associated with coverage under
9 the qualified health plan and the TIN of the indi-
10 vidual covered under such coverage for such month
11 is included on the return for the taxable year in
12 which such month occurs.

13 “(d) QUALIFIED HEALTH INSURANCE.—For pur-
14 poses of this section, the term ‘qualified health insurance’
15 means coverage under—

16 “(1) a qualified core plan certified under sec-
17 tion 102 of the Ten Steps to Transform Health Care
18 in America Act , and

19 “(2) any plan certified under section 103 of
20 such Act as a qualified core compatible plan with re-
21 spect to a qualified core plan.

22 “(e) ARCHER MSA AND HEALTH SAVINGS ACCOUNT
23 CONTRIBUTIONS.—

24 “(1) IN GENERAL.—If a deduction would (but
25 for paragraph (2)) be allowed under section 220 or

1 223 to the taxpayer for a payment for the taxable
2 year to the Archer MSA or health savings account
3 of an individual established in connection with quali-
4 fied health insurance, subsection (a) shall be applied
5 by treating such payment as a payment for qualified
6 health insurance for such individual.

7 “(2) DENIAL OF DOUBLE BENEFIT.—No deduc-
8 tion shall be allowed under section 220 or 223 for
9 that portion of the payments otherwise allowable as
10 a deduction under section 220 or 223 for the taxable
11 year which is equal to the amount of credit allowed
12 for such taxable year by reason of this subsection.

13 “(f) SPECIAL RULES.—For purposes of this sec-
14 tion—

15 “(1) MARRIED COUPLES MUST FILE JOINT RE-
16 TURN.—If the taxpayer is married at the close of
17 the taxable year, the credit shall be allowed under
18 subsection (a) only if the taxpayer and the tax-
19 payer’s spouse file a joint return for the taxable
20 year.

21 “(2) DENIAL OF CREDIT TO DEPENDENTS.—No
22 credit shall be allowed under this section to any indi-
23 vidual with respect to whom a deduction under sec-
24 tion 151 is allowable to another taxpayer for a tax-

able year beginning in the calendar year in which such individual's taxable year begins.

“(3) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under subsection (a) if the credit under section 35 is allowed and no credit shall be allowed under 35 if a credit is allowed under this section.

“(4) SPECIAL RULE FOR DIVORCED PARENTS, ETC.—A rule similar to the rule of section 224(c)(5) shall apply for purposes of this section.

“(5) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.”.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period “, or from section 36 of such Code”.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

“Sec. 36. Refundable credit for health insurance coverage.

“Sec. 37. Overpayments of tax.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or

1 after the first day of the first calendar year in which oc-
 2 curs the first date on which the requirement of section
 3 101(a) of this Act applies.

4 **SEC. 132. ADVANCE PAYMENT OF CREDIT FOR PUR-**
 5 **CHASERS OF QUALIFIED HEALTH INSUR-**
 6 **ANCE.**

7 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
 8 enue Code of 1986 (relating to miscellaneous provisions)
 9 is amended by adding at the end the following new section:
 10 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR PUR-**
 11 **CHASERS OF QUALIFIED HEALTH INSUR-**
 12 **ANCE.**

13 “(a) GENERAL RULE.—In the case of an eligible indi-
 14 vidual, the Secretary shall make payments to the provider
 15 of such individual’s qualified health insurance equal to
 16 such individual’s qualified health insurance credit advance
 17 amount with respect to such provider.

18 “(b) ELIGIBLE INDIVIDUAL.—For purposes of this
 19 section, the term ‘eligible individual’ means any indi-
 20 vidual—

21 “(1) who purchases qualified health insurance
 22 (as defined in section 36(d)), and

23 “(2) for whom a qualified health insurance
 24 credit eligibility certificate is in effect.

1 “(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGI-
2 BILITY CERTIFICATE.—For purposes of this section, a
3 qualified health insurance credit eligibility certificate is a
4 statement furnished by an individual to the Secretary
5 which—

6 “(1) certifies that the individual will be eligible
7 to receive the credit provided by section 36 for the
8 taxable year,

9 “(2) estimates the amount of such credit for
10 such taxable year, and

11 “(3) provides such other information as the
12 Secretary may require for purposes of this section.

13 “(d) QUALIFIED HEALTH INSURANCE CREDIT AD-
14 VANCE AMOUNT.—For purposes of this section, the term
15 ‘qualified health insurance credit advance amount’ means,
16 with respect to any provider of qualified health insurance,
17 the lesser of—

18 “(1) the Secretary’s estimate of the amount of
19 credit allowable under section 36 to the individual
20 for the taxable year which is attributable to the in-
21 surance provided to the individual by such provider,
22 or

23 “(2) the aggregate premiums with respect to
24 such insurance for months occurring during such
25 taxable year.

1 “(e) REGULATIONS.—The Secretary shall prescribe
2 such regulations as may be necessary to carry out the pur-
3 poses of this section.”.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

“Sec. 7529. Advance payment of credit for purchasers of qualified health insurance.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

12 SEC. 133. DESIGNATION OF HEALTH INSURANCE STATUS
13 REQUIRED BY INDIVIDUALS ON FEDERAL IN-
14 COME TAX RETURNS.

(a) IN GENERAL.—Subchapter B of chapter 61 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions involving information and returns) is amended by redesignating section 6116 as section 6117 and by inserting after section 6115 the following new section:

20 “SEC. 6116. DESIGNATION OF HEALTH INSURANCE STATUS
21 REQUIRED BY INDIVIDUALS ON FEDERAL IN-
22 COME TAX RETURNS.

23 “(a) GENERAL RULE.—In the case of an individual,
24 if a taxpayer is required to file a return of tax imposed

1 by chapter 1 for such taxable year, the taxpayer shall in-
2 clude with such return the designation described in sub-
3 section (b) with respect to the taxpayer and the spouse
4 or any dependent of the taxpayer with respect to whom
5 a deduction under section 151 is allowed to the taxpayer
6 for the taxable year.

7 “(b) DESIGNATION.—

8 “(1) IN GENERAL.—The taxpayer shall des-
9 ignate with respect to each individual described in
10 subsection (a) which of the following categories of
11 health insurance coverage is applicable to the indi-
12 vidual as of the close of the taxable year for which
13 the return is being filed:

14 “(A) Coverage under a qualified health
15 plan (as defined in section 224(d)(2)).

16 “(B) Coverage under qualified health in-
17 surance (as defined in section 36(d)).

18 “(C) Coverage under an employer-spon-
19 sored health plan which is licensed and regu-
20 lated by the State in which the individual re-
21 sides.

22 “(D) Coverage under an employer-spon-
23 sored, self-insured health plan which meets the
24 requirements of the Employee Retirement In-

1 come Security Act of 1974 and any other appli-
2 cable law.

3 “(E) Coverage described in clause (i), (ii),
4 or (iii) of section 224(d)(1)(B) (relating to cov-
5 erage under medicare, medicaid, schip or grand-
6 fathered employer coverage).

7 “(F) Coverage not described in any of the
8 preceding subparagraphs.

9 “(G) No coverage.

10 “(2) FORM AND MANNER.—The Secretary shall
11 prescribe the form and manner of making the des-
12 ignation under this section.”.

13 (b) CONFORMING AMENDMENTS.—The table of sec-
14 tions for subchapter B of chapter 61 of such Code is
15 amended by striking the item relating to section 6116 and
16 inserting the following new items:

“Sec. 6116. Designation of health insurance status required by individuals on
Federal income tax returns.

“Sec. 6117. Cross reference.”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to taxable years beginning in—

19 (1) the calendar year preceding the first cal-
20 endar year in which occurs the first date on which
21 the requirement of section 101(a) of this Act ap-
22 plies, and

23 (2) any calendar year following the calendar
24 year described in paragraph (1).

Subtitle D—Education and Outreach

SEC. 141. NOTICE TO TAXPAYERS OF AVAILABILITY OF STANDARD DEDUCTION FOR HEALTH INSUR- ANCE AND REFUNDABLE HEALTH INSUR- ANCE CREDIT.

The Secretary of the Treasury or the Secretary's del-
egate shall ensure that—

(1) any instructions booklet accompanying an individual Federal income tax return form (including forms 1040, 1040A, 1040EZ, and any similar or successor forms) , and

(2) any other publication, announcement, or website that the Secretary or the Secretary's dele-
gate considers appropriate,

shall include, in clear language, in conspicuous print, and in a conspicuous place, information with respect to the availability of the standard deduction for health insurance or the health insurance tax credit for individuals enrolled in qualified core health plans and qualified core compatible plans certified as meeting the requirements of this Act. The requirement of this section shall apply with respect to booklets, publications, announcements, or information on websites made available on and after the date that is

1 1 year before the first date on which the coverage require-
2 ment under section 101(a) of this Act becomes effective.

3 **SEC. 142. OPTIONAL ENROLLMENT AND OUTREACH.**

4 (a) OPTION FOR MEDICAID OR SCHIP ELIGIBLE IN-
5 DIVIDUALS TO ENROLL IN A QUALIFIED CORE PLAN.—
6 The Secretary of Health and Human Services, in consulta-
7 tion with the Secretary of the Treasury and the States,
8 shall establish a process for permitting an individual who
9 is eligible for medical assistance under a State plan or
10 waiver under title XIX of the Social Security Act, or for
11 child health assistance or other health benefits coverage
12 under a State child health plan or waiver under title XXI
13 of such Act, to elect to enroll (or in the case of an indi-
14 vidual who is a child under age 18, for the individual's
15 family to elect to be enrolled) in a qualified core plan of-
16 fered in the State of residence of the individual in lieu
17 of being enrolled in such State plan or waiver for the year.
18 The process established pursuant to this subsection
19 shall—

20 (1) allow for such an election to be made on an
21 annual basis;

22 (2) require the State of residence of the indi-
23 vidual to notify the Secretary of Health and Human
24 Services and the Secretary of the Treasury of the
25 actuarial value of the benefits and cost-sharing pro-

1 tection that would have been provided to the indi-
2 vidual under the State plan or waiver under title
3 XIX or XXI of the Social Security Act for the year;

4 (3) allow for an increase in the refundable cred-
5 it established under section 36 of the Internal Rev-
6 enue Code of 1986 for the year in an amount equal
7 to the actuarial value determined for purposes of
8 paragraph (2); and

9 (4) require, as a condition of the continued ap-
10 proval of such State plans or waivers, for the Sec-
11 retary of Health and Human Services to reduce the
12 amount to be paid to the State of residence of the
13 individual under section 1903(a) or 2105(a) of the
14 Social Security Act (as appropriate) for each cal-
15 endar quarter occurring during the year for which
16 such credit applies by an amount equal to $\frac{1}{4}$ of the
17 State share of the amount described in paragraph
18 (3).

19 (b) ADDITIONAL OUTREACH.—

20 (1) ESTABLISHMENT OF OUTREACH PRO-
21 GRAM.—Not later than 1 year after the date of en-
22 actment of this Act, the Secretary of Health and
23 Human Services, in consultation with the Secretary
24 of the Treasury, the States, and representatives of
25 community health centers, hospitals, and other

1 health care providers, shall establish a program
2 under which the Secretary of Health and Human
3 Services shall provide access to informational mate-
4 rials regarding the standard deduction for health in-
5 surance established under section 224 of the Inter-
6 nal Revenue Code of 1986 and the refundable credit
7 established under section 36 of such Code, including
8 State-specific contact information for more detailed
9 information and assistance, through health care pro-
10 viders and a national Internet website that meets
11 the requirements of paragraph (1).

12 (2) TARGETING OF HEALTH CARE PROVIDERS
13 THAT SERVE THE UNINSURED AND THE UNDER IN-
14 SURED.—The program established under paragraph
15 (1) shall give priority to disseminating such informa-
16 tion through those health care providers that pri-
17 marily serve uninsured or under insured individuals.

18 (3) NATIONAL INFORMATION WEBSITE.—For
19 purposes of paragraph (1), the requirements of this
20 subparagraph are that the Secretary of Health and
21 Human Services establishes a one-stop website that
22 provides information on the standard deduction for
23 health insurance established under section 224 of
24 the Internal Revenue Code of 1986 and the health

1 insurance tax credit established under section 36 of
2 Code. The website shall—

3 (A) include significant timelines for action,
4 a general description of enrollment processes,
5 and links to State insurance commissioners'
6 sites, which approve qualified core plans and
7 shall provide a portal for comparison of such
8 plans with respect to each State; and

9 (B) provide such information in a manner
10 that—

11 (i) is concise, clear, and easy to un-
12 derstand;

13 (ii) allows the information to be
14 accessed in a downloadable format;

15 (iii) provides appropriate links or con-
16 tacts for further information; and

17 (iv) allows for use by providers in
18 order to inform consumers at the point of
19 delivery of health care items and services.

1 **TITLE II—INCREASING INSUR-**
2 **ANCE MARKET PORTABILITY**
3 **AND AFFORDABILITY**

4 **Subtitle A—Merging and**
5 **Improving Insurance Markets**

6 **SEC. 201. DEVELOPMENT OF MERGED AND IMPROVED**
7 **STATE INSURANCE MARKET STANDARDS.**

8 (a) IN GENERAL.—The Secretary, in consultation
9 with State insurance commissioners and the National As-
10 sociation of Insurance Commissioners, shall promulgate
11 regulations providing for the establishment in each State
12 of a single market for all health plans (other than self-
13 funded plans or Federal or State governmental health cov-
14 erage programs) offered in each State.

15 (b) REQUIREMENTS.—The regulations promulgated
16 under subsection (a) shall, with respect to each State, re-
17 quire—

18 (1) that State health insurance laws applicable
19 to the small group market in the State be modified,
20 except as provided for otherwise in this Act, to apply
21 to all health plans offered in the State regardless of
22 whether such plans are being purchased for the cov-
23 erage of individuals or for groups;

24 (2) that the provisions of part A of title XXVII
25 of the Public Health Service Act (42 U.S.C. 300gg

et seq.) (relating to group market rules) shall apply to all health plans offered in the State, subject to such modification as may be necessary to clarify and effectuate the application of such rules to all such health plans;

(3) that the provisions of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.) (relating to individual market rules), and any other provisions or definitions within such title XXVII that apply independent standards to individual insurance markets or that relate to the relationship between such markets and group markets, shall be superseded by the provisions of this Act and shall have no force or effect; and

(4) that each health plan offered in the State fully comply with all standards provided for in this subsection, and that such standards, if not provided for otherwise in this Act, shall include requirements that each health plan—

(A) must accept for enrollment under such plan every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll in such plan and may not place any restriction which is inconsistent with section 2702 or 2711 of the

1 Public Health Service Act (42 U.S.C. 300gg-1
2 and 300gg-11) on an eligible individual enroll-
3 ing in such plan;

4 (B) must renew or continue in force cov-
5 erage under such plan at the option of the en-
6 rollee in accordance with section 2712 of such
7 Act (42 U.S.C. 300gg-12);

8 (C) must ensure that there is no re-under-
9 writing of such plan; and

10 (D) must comply with the portability re-
11 quirements of section 2701 of such Act (42
12 U.S.C. 300gg);

13 (5) that the State comply with the regulations
14 promulgated under section 211(d) with respect to re-
15 ducing the effect of such material risk selection as
16 may occur among health plans (including self-in-
17 sured plans) through the establishment of State-
18 based risk adjustment requirements.

19 **SEC. 202. MODIFICATIONS RELATING TO SELF-FUNDED**
20 **GROUP HEALTH PLANS.**

21 (a) ERISA.—Section 734 of the Employee Retire-
22 ment Income Security Act of 1974 (29 U.S.C. 1191c) is
23 amended—

24 (1) by striking “The Secretary” and inserting
25 the following:

1 “(a) IN GENERAL.—The Secretary”; and

2 (2) by adding at the end the following:

3 “(b) MODIFICATION RELATING TO THE ELIMINATION
4 OF THE INDIVIDUAL MARKETS.—

5 “(1) IN GENERAL.—The Secretary shall pro-
6 mulgate regulations, or modify existing regulations,
7 under this part as the Secretary determines nec-
8 essary to reflect changes in State law pursuant to
9 the Ten Steps to Transform Health Care in America
10 Act (and the amendments made by that Act) with
11 respect to the treatment of individual State health
12 insurance markets and to ensure the continued ap-
13 plication of this part to self-funded group health
14 plans notwithstanding such changes.

15 “(2) CLARIFICATIONS.—The regulations or
16 modification promulgated under paragraph (1) shall
17 not be construed as otherwise materially altering the
18 provisions of this part as such provisions apply to
19 self-funded group health plans. Nothing in this sub-
20 section shall be construed to preempt the application
21 of State insurance laws with respect to State regu-
22 lated health insurance products.”.

23 (b) INTERNAL REVENUE CODE.—Section 9833 of the
24 Internal Revenue Code of 1986 is amended—

1 (1) by striking “The Secretary” and inserting
2 the following:

3 “(a) IN GENERAL.—The Secretary”; and

4 (2) by adding at the end the following:

5 “(b) MODIFICATION RELATING TO THE ELIMINATION
6 OF THE INDIVIDUAL MARKETS.—

7 “(1) IN GENERAL.—The Secretary shall pro-
8 mulgate regulations, or modify existing regulations,
9 under this chapter as the Secretary determines nec-
10 essary to reflect changes in State law pursuant to
11 the Ten Steps to Transform Health Care in America
12 Act (and the amendments made by that Act) with
13 respect to the treatment of individual State health
14 insurance markets and to ensure the continued ap-
15 plication of this part to self-funded group health
16 plans notwithstanding such changes.

17 “(2) CLARIFICATIONS.—The regulations or
18 modification promulgated under paragraph (1) shall
19 not be construed as otherwise materially altering the
20 provisions of this part as such provisions apply to
21 self-funded group health plans. Nothing in this sub-
22 section shall be construed to preempt the application
23 of State insurance laws with respect to State regu-
24 lated health insurance products.”.

1 **SEC. 203. LEGISLATIVE PROPOSALS.**

2 Not later than 1 year after the date of enactment
3 of this Act, and every 3 years thereafter, the Secretary
4 of Health and Human Services, the Secretary of Labor,
5 and the Secretary or the Treasury, in consultation with
6 the National Association of Insurance Commissioners,
7 shall jointly conduct a review of the effect of this subtitle
8 (and the regulations promulgated thereunder) on health
9 insurance access and affordability, particularly for individ-
10 uals with chronic illness or catastrophic medical expenses,
11 and on market competition, and shall submit a report con-
12 cerning such review to the appropriate committees of Con-
13 gress that contains proposals for such amendments as
14 each such Secretary may determine would substantially
15 improve the effectiveness and the implementation of this
16 subtitle.

17 **SEC. 204. ENFORCEMENT.**

18 The provisions of section 106 shall apply with respect
19 to the implementation and enforcement of the require-
20 ments of this subtitle in the same manner as such provi-
21 sions apply to subtitle A of title I.

1 **Subtitle B—Reduction in Premium**
2 **Variation and Health Status Dis-**
3 **crimination**

4 **SEC. 211. DEVELOPMENT OF STANDARDS FOR REDUCTION**
5 **IN PREMIUM VARIATION AND HEALTH STA-**
6 **TUS DISCRIMINATION AMONG ENROLLEES.**

7 (a) IN GENERAL.—The Secretary, in consultation
8 with State insurance commissioners and the National As-
9 sociation of Insurance Commissioners, shall promulgate
10 regulations providing for the application by each State in
11 the health insurance market of such State of improved
12 standards regarding the range of allowable premium vari-
13 ation for enrollees.

14 (b) REQUIREMENTS.—The regulations promulgated
15 under subsection (a) shall, with respect to each State, re-
16 quire—

17 (1) that for qualified core plans offered in the
18 State—

19 (A) no premium variation based on health
20 status or any other factor shall be permitted;
21 and

22 (B) the standard premium amount shall be
23 the same for all enrollees;

24 (2) that for compatible qualified core plans of-
25 fered in the State—

(A) no premium variation based on health status shall be permitted; and

(B) rating variation based on enrollee age shall be the only permitted rating factor so long as the total variation in premium rates charged by an issuer for coverage under such plan shall not be greater than a factor of 2:1; and

(3) that for all other health insurance products offered in the State—

(A) no premium variation based on health status shall be permitted; and

(B) except as otherwise provided in this paragraph, premium variation shall be permitted as determined by State law, subject to the application of small group market rules to all insured health plan in a State pursuant to section 201(a) and (b).

(c) STATE RATING DISCRETION OTHERWISE PERMITTED.—Except as provided for in subsection (b), nothing in this section shall be construed to preempt the State application of such health insurance premium rating factors as a State may determine appropriate.

(d) STATE-BASED RISK ADJUSTMENTS.—

(1) IN GENERAL.—The regulations promulgated under subsection (a) and otherwise promulgated

1 under this subtitle shall require the State to estab-
 2 lish risk adjustment requirements to reduce the ef-
 3 fect of such material risk selection as may occur
 4 among qualified core plans, qualified core compatible
 5 plans, and other health plans in a State (not includ-
 6 ing self-insured plans) through the application of
 7 State risk adjustment requirements that are certified
 8 by the Secretary, pursuant to such regulations, as
 9 meeting standards established by the Secretary (in
 10 consultation with the National Association of Insur-
 11 ance Commissioners).

12 (2) ASSESSMENT AND REPORT ON STATE-
 13 BASED RISK ADJUSTMENT.—

14 (A) IN GENERAL.—Prior to the promulga-
 15 tion of standards under paragraph (1), the Sec-
 16 retary, in consultation with the National Asso-
 17 ciation of Insurance Commissioners, shall con-
 18 duct an assessment of—

19 (i) the degree of significant actual or
 20 actuarially anticipated material adverse se-
 21 lection among qualified core plans, quali-
 22 fied core compatible plans, and other in-
 23 sured health plans in a State; and

24 (ii) the comparative effectiveness of
 25 State risk adjustment requirement options

1 or mechanisms to reduce the effect of such
2 adverse selection.

3 (B) REPORT.—The Secretary shall submit
4 a report to Congress concerning the results of
5 the assessment conducted under subparagraph
6 (A). Such report may include recommendations
7 by the Secretary for additional or future legisla-
8 tion to adjust the standards developed under
9 paragraph (1) if the Secretary determines that
10 such legislation is reasonably necessary to ma-
11 terially improve the effective application of
12 State-based risk adjustment requirements pur-
13 suant to paragraph (1).

14 (e) STUDY AND REPORT ON PREMIUM RATING.—

15 (1) STUDY.—The Secretary, in consultation
16 with the National Association of Insurance Commis-
17 sioners, shall conduct ongoing reviews of the effect
18 modification of State health insurance premium rat-
19 ing rules under this section will have, or has had, on
20 health insurance affordability, access, and market
21 competition in the insurance market in the States
22 and on a national basis.

23 (2) REPORTS.—Not later than 1 year after the
24 date of enactment of this Act, and every 2 years
25 thereafter, the Secretary shall submit to the appro-

1 appropriate committees of Congress a report concerning
 2 the study conducted under paragraph (1), which
 3 may, as the Secretary may determine, include rec-
 4 ommendations concerning proposed modifications
 5 and adjustments with respect to State premium rat-
 6 ing rules.

7 **SEC. 212. ENFORCEMENT.**

8 The provisions of section 106 shall apply with respect
 9 to the implementation and enforcement of the require-
 10 ments of this subtitle in the same manner as such provi-
 11 sions apply to subtitle A of title I.

12 **Subtitle C—Enhanced Marketplace**
 13 **Pooling and Related Market Rating**

14 **PART I—ENHANCED MARKETPLACE POOLS**

15 **SEC. 245. RULES GOVERNING ENHANCED MARKETPLACE**
 16 **POOLS.**

17 (a) IN GENERAL.—Subtitle B of title I of the Em-
 18 ployee Retirement Income Security Act of 1974 is amend-
 19 ed by adding after part 7 the following new part:

20 **“PART 8—RULES GOVERNING ENHANCED**
 21 **MARKETPLACE POOLS**

22 **“SEC. 801. SMALL BUSINESS HEALTH PLANS.**

23 “(a) IN GENERAL.—For purposes of this part, the
 24 term ‘small business health plan’ means a fully insured

1 group health plan whose sponsor is (or is deemed under
2 this part to be) described in subsection (b).

3 “(b) SPONSORSHIP.—The sponsor of a group health
4 plan is described in this subsection if such sponsor—

5 “(1) is organized and maintained in good faith,
6 with a constitution and bylaws specifically stating its
7 purpose and providing for periodic meetings on at
8 least an annual basis, as a bona fide trade associa-
9 tion, a bona fide industry association (including a
10 rural electric cooperative association or a rural tele-
11 phone cooperative association), a bona fide profes-
12 sional association, or a bona fide chamber of com-
13 merce (or similar bona fide business association, in-
14 cluding a corporation or similar organization that
15 operates on a cooperative basis (within the meaning
16 of section 1381 of the Internal Revenue Code of
17 1986)), for substantial purposes other than that of
18 obtaining medical care;

19 “(2) is established as a permanent entity which
20 receives the active support of its members and re-
21 quires for membership payment on a periodic basis
22 of dues or payments necessary to maintain eligibility
23 for membership;

24 “(3) does not condition membership, such dues
25 or payments, or coverage under the plan on the

1 basis of health status-related factors with respect to
2 the employees of its members (or affiliated mem-
3 bers), or the dependents of such employees, and does
4 not condition such dues or payments on the basis of
5 group health plan participation; and

6 “(4) does not condition membership on the
7 basis of a minimum group size.

8 Any sponsor consisting of an association of entities which
9 meet the requirements of paragraphs (1), (2), (3), and (4)
10 shall be deemed to be a sponsor described in this sub-
11 section.

12 **“SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZA-**
13 **TIONS.**

14 “(a) IN GENERAL.—The Secretary, not later than 1
15 year after the date of enactment of this part, shall promul-
16 gate regulations that apply the rules and standards of this
17 part, as necessary, to circumstances in which a pooling
18 entity other (hereinafter ‘Alternative Market Pooling Or-
19 ganizations’) is not made up principally of employers and
20 their employees, or not a professional organization or such
21 small business health plan entity identified in section 801.

22 “(b) ADAPTION OF STANDARDS.—In developing and
23 promulgating regulations pursuant to subsection (a), the
24 Secretary, in consultation with the Secretary of Health
25 and Human Services, small business health plans, small

1 and large employers, large and small insurance issuers,
2 consumer representatives, and state insurance commis-
3 sioners, shall—

4 “(1) adapt the standards of this part, to the
5 maximum degree practicable, to assure balanced and
6 comparable oversight standards for both small busi-
7 ness health plans and alternative market pooling or-
8 ganizations;

9 “(2) permit the participation as alternative
10 market pooling organizations unions, churches and
11 other faith-based organizations, or other organiza-
12 tions composed of individuals and groups which may
13 have little or no association with employment, pro-
14 vided however, that such alternative market pooling
15 organizations meet, and continue meeting on an on-
16 going basis, to satisfy standards, rules, and require-
17 ments materially equivalent to those set forth in this
18 part with respect to small business health plans;

19 “(3) conduct periodic verification of such com-
20 pliance by alternative market pooling organizations,
21 in consultation with the Secretary of Health and
22 Human Services and the National Association of In-
23 surance Commissioners, except that such periodic
24 verification shall not materially impede market entry

1 or participation as pooling entities comparable to
2 that of small business health plans; and

3 “(4) assure that consistent, clear, and regularly
4 monitored standards are applied with respect to al-
5 ternative market pooling organizations to avert ma-
6 terial risk-selection within or among the composition
7 of such organizations;

8 “(5) the expedited and deemed certification pro-
9 cedures provided in section 805(d) shall not apply to
10 alternative market pooling organizations until sooner
11 of the promulgation of regulations under this sub-
12 section or the expiration of one year following enact-
13 ment of this Act; and

14 “(6) make such other appropriate adjustments
15 to the requirements of this part as the Secretary
16 may reasonably deem appropriate to fit the cir-
17 cumstances of an individual alternative market pool-
18 ing organization or category of such organization,
19 including but not limited to the application of the
20 membership payment requirements of section
21 801(b)(2) to alternative market pooling organiza-
22 tions composed primarily of church- or faith-based
23 membership.

1 **“SEC. 803. CERTIFICATION OF SMALL BUSINESS HEALTH**
2 **PLANS.**

3 “(a) IN GENERAL.—Not later than 6 months after
4 the date of enactment of this part, the applicable authority
5 shall prescribe by interim final rule a procedure under
6 which the applicable authority shall certify small business
7 health plans which apply for certification as meeting the
8 requirements of this part.

9 “(b) REQUIREMENTS APPLICABLE TO CERTIFIED
10 PLANS.—A small business health plan with respect to
11 which certification under this part is in effect shall meet
12 the applicable requirements of this part, effective on the
13 date of certification (or, if later, on the date on which the
14 plan is to commence operations).

15 “(c) REQUIREMENTS FOR CONTINUED CERTIFI-
16 CATION.—The applicable authority may provide by regula-
17 tion for continued certification of small business health
18 plans under this part. Such regulation shall provide for
19 the revocation of a certification if the applicable authority
20 finds that the small business health plan involved is failing
21 to comply with the requirements of this part.

22 “(d) EXPEDITED AND DEEMED CERTIFICATION.—

23 “(1) IN GENERAL.—If the Secretary fails to act
24 on an application for certification under this section
25 within 90 days of receipt of such application, the ap-
26 plying small business health plan shall be deemed

1 certified until such time as the Secretary may deny
2 for cause the application for certification.

3 “(2) CIVIL PENALTY.—The Secretary may as-
4 sess a civil penalty against the board of trustees and
5 plan sponsor (jointly and severally) of a small busi-
6 ness health plan that is deemed certified under para-
7 graph (1) of up to \$500,000 in the event the Sec-
8 retary determines that the application for certifi-
9 cation of such small business health plan was will-
10 fully or with gross negligence incomplete or inac-
11 curate.

12 **“SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND**
13 **BOARDS OF TRUSTEES.**

14 “(a) SPONSOR.—The requirements of this subsection
15 are met with respect to a small business health plan if
16 the sponsor has met (or is deemed under this part to have
17 met) the requirements of section 801(b) for a continuous
18 period of not less than 3 years ending with the date of
19 the application for certification under this part.

20 “(b) BOARD OF TRUSTEES.—The requirements of
21 this subsection are met with respect to a small business
22 health plan if the following requirements are met:

23 “(1) FISCAL CONTROL.—The plan is operated,
24 pursuant to a plan document, by a board of trustees
25 which pursuant to a trust agreement has complete

fiscal control over the plan and which is responsible for all operations of the plan.

“(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

“(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

“(A) BOARD MEMBERSHIP.—

“(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

“(ii) LIMITATION.—

“(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in,

1 a contract administrator or other
2 service provider to the plan.

3 “(II) LIMITED EXCEPTION FOR
4 PROVIDERS OF SERVICES SOLELY ON
5 BEHALF OF THE SPONSOR.—Officers
6 or employees of a sponsor which is a
7 service provider (other than a contract
8 administrator) to the plan may be
9 members of the board if they con-
10 stitute not more than 25 percent of
11 the membership of the board and they
12 do not provide services to the plan
13 other than on behalf of the sponsor.

14 “(III) TREATMENT OF PRO-
15 VIDERS OF MEDICAL CARE.—In the
16 case of a sponsor which is an associa-
17 tion whose membership consists pri-
18 marily of providers of medical care,
19 subclause (I) shall not apply in the
20 case of any service provider described
21 in subclause (I) who is a provider of
22 medical care under the plan.

23 “(iii) CERTAIN PLANS EXCLUDED.—
24 Clause (i) shall not apply to a small busi-
25 ness health plan which is in existence on

1 the date of the enactment of the Health
2 Insurance Marketplace Modernization and
3 Affordability Act of 2007.

4 “(B) SOLE AUTHORITY.—The board has
5 sole authority under the plan to approve appli-
6 cations for participation in the plan and to con-
7 tract with insurers.

8 “(c) TREATMENT OF FRANCHISES.—In the case of
9 a group health plan which is established and maintained
10 by a franchiser for a franchisor or for its franchisees—

11 “(1) the requirements of subsection (a) and sec-
12 tion 801(a) shall be deemed met if such require-
13 ments would otherwise be met if the franchisor were
14 deemed to be the sponsor referred to in section
15 801(b) and each franchisee were deemed to be a
16 member (of the sponsor) referred to in section
17 801(b); and

18 “(2) the requirements of section 804(a)(1) shall
19 be deemed met.

20 For purposes of this subsection the terms ‘franchisor’ and
21 ‘franchisee’ shall have the meanings given such terms for
22 purposes of sections 436.2(a) through 436.2(c) of title 16,
23 Code of Federal Regulations (including any such amend-
24 ments to such regulation after the date of enactment of
25 this part).

1 **“SEC. 805. PARTICIPATION AND COVERAGE REQUIRE-**
2 **MENTS.**

3 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
4 requirements of this subsection are met with respect to
5 a small business health plan if, under the terms of the
6 plan—

7 “(1) each participating employer must be—

8 “(A) a member of the sponsor;

9 “(B) the sponsor; or

10 “(C) an affiliated member of the sponsor,
11 except that, in the case of a sponsor which is
12 a professional association or other individual-
13 based association, if at least one of the officers,
14 directors, or employees of an employer, or at
15 least one of the individuals who are partners in
16 an employer and who actively participates in
17 the business, is a member or such an affiliated
18 member of the sponsor, participating employers
19 may also include such employer; and

20 “(2) all individuals commencing coverage under
21 the plan after certification under this part must
22 be—

23 “(A) active or retired owners (including
24 self-employed individuals), officers, directors, or
25 employees of, or partners in, participating em-
26 ployers; or

1 “(B) the dependents of individuals de-
2 scribed in subparagraph (A).

3 “(b) INDIVIDUAL MARKET UNAFFECTED.—The re-
4 quirements of this subsection are met with respect to a
5 small business health plan if, under the terms of the plan,
6 no participating employer may provide health insurance
7 coverage in the individual market for any employee not
8 covered under the plan which is similar to the coverage
9 contemporaneously provided to employees of the employer
10 under the plan, if such exclusion of the employee from cov-
11 erage under the plan is based on a health status-related
12 factor with respect to the employee and such employee
13 would, but for such exclusion on such basis, be eligible
14 for coverage under the plan.

15 “(c) PROHIBITION OF DISCRIMINATION AGAINST EM-
16 PLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—
17 The requirements of this subsection are met with respect
18 to a small business health plan if—

19 “(1) under the terms of the plan, all employers
20 meeting the preceding requirements of this section
21 are eligible to qualify as participating employers for
22 all geographically available coverage options, unless,
23 in the case of any such employer, participation or
24 contribution requirements of the type referred to in

1 section 2711 of the Public Health Service Act are
2 not met;

3 “(2) information regarding all coverage options
4 available under the plan is made readily available to
5 any employer eligible to participate; and

6 “(3) the applicable requirements of sections
7 701, 702, and 703 are met with respect to the plan.

8 **“SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN**
9 **DOCUMENTS, CONTRIBUTION RATES, AND**
10 **BENEFIT OPTIONS.**

11 “(a) IN GENERAL.—The requirements of this section
12 are met with respect to a small business health plan if
13 the following requirements are met:

14 “(1) CONTENTS OF GOVERNING INSTRU-
15 MENTS.—

16 “(A) IN GENERAL.—The instruments gov-
17 erning the plan include a written instrument,
18 meeting the requirements of an instrument re-
19 quired under section 402(a)(1), which—

20 “(i) provides that the board of trust-
21 ees serves as the named fiduciary required
22 for plans under section 402(a)(1) and
23 serves in the capacity of a plan adminis-
24 trator (referred to in section 3(16)(A));
25 and

1 “(ii) provides that the sponsor of the
2 plan is to serve as plan sponsor (referred
3 to in section 3(16)(B)).

4 “(B) DESCRIPTION OF MATERIAL PROVI-
5 SIONS.—The terms of the health insurance cov-
6 erage (including the terms of any individual
7 certificates that may be offered to individuals in
8 connection with such coverage) describe the ma-
9 terial benefit and rating, and other provisions
10 set forth in this section and such material pro-
11 visions are included in the summary plan de-
12 scription.

13 “(2) CONTRIBUTION RATES MUST BE NON-
14 DISCRIMINATORY.—

15 “(A) IN GENERAL.—The contribution rates
16 for any participating small employer shall not
17 vary on the basis of any health status-related
18 factor in relation to employees of such employer
19 or their beneficiaries and shall not vary on the
20 basis of the type of business or industry in
21 which such employer is engaged, subject to sub-
22 paragraph (B) and the terms of this title.

23 “(B) EFFECT OF TITLE.—Nothing in this
24 title or any other provision of law shall be con-
25 strued to preclude a health insurance issuer of-

1 fering health insurance coverage in connection
2 with a small business health plan that meets
3 the requirements of this part, and at the re-
4 quest of such small business health plan,
5 from—

6 “(i) setting contribution rates for the
7 small business health plan based on the
8 claims experience of the small business
9 health plan so long as any variation in
10 such rates for participating small employ-
11 ers complies with the requirements of
12 clause (ii), except that small business
13 health plans shall not be subject, in non-
14 adopting states, to subparagraphs (A)(ii)
15 and (C) of section 2912(a)(2) of the Public
16 Health Service Act, and in adopting states,
17 to any State law that would have the effect
18 of imposing requirements as outlined in
19 such subparagraphs (A)(ii) and (C); or

20 “(ii) varying contribution rates for
21 participating small employers in a small
22 business health plan in a State to the ex-
23 tent that such rates could vary using the
24 same methodology employed in such State
25 for regulating small group premium rates,

1 subject to the terms of part I of subtitle A
2 of title XXIX of the Public Health Service
3 Act (relating to rating requirements), as
4 added by title II of the Health Insurance
5 Marketplace Modernization and Afford-
6 ability Act of 2007.

7 “(3) EXCEPTIONS REGARDING SELF-EMPLOYED
8 AND LARGE EMPLOYERS.—

9 “(A) SELF EMPLOYED.—

10 “(i) IN GENERAL.—Small business
11 health plans with participating employers
12 who are self-employed individuals (and
13 their dependents) shall enroll such self-em-
14 ployed participating employers in accord-
15 ance with rating rules that do not violate
16 the rating rules for self-employed individ-
17 uals in the State in which such self-em-
18 ployed participating employers are located.

19 “(ii) GUARANTEE ISSUE.—Small busi-
20 ness health plans with participating em-
21 ployers who are self-employed individuals
22 (and their dependents) may decline to
23 guarantee issue to such participating em-
24 ployers in States in which guarantee issue

1 is not otherwise required for the self-em-
2 ployed in that State.

3 “(B) LARGE EMPLOYERS.—Small business
4 health plans with participating employers that
5 are larger than small employers (as defined in
6 section 808(a)(10)) shall enroll such large par-
7 ticipating employers in accordance with rating
8 rules that do not violate the rating rules for
9 large employers in the State in which such large
10 participating employers are located.

11 “(4) REGULATORY REQUIREMENTS.—Such
12 other requirements as the applicable authority deter-
13 mines are necessary to carry out the purposes of this
14 part, which shall be prescribed by the applicable au-
15 thority by regulation.

16 “(b) ABILITY OF SMALL BUSINESS HEALTH PLANS
17 TO DESIGN BENEFIT OPTIONS.—Nothing in this part or
18 any provision of State law (as defined in section
19 514(c)(1)) shall be construed to preclude a small business
20 health plan or a health insurance issuer offering health
21 insurance coverage in connection with a small business
22 health plan from exercising its sole discretion in selecting
23 the specific benefits and services consisting of medical care
24 to be included as benefits under such plan or coverage,
25 except that such benefits and services must meet the terms

1 and specifications of part II of subtitle A of title XXIX
2 of the Public Health Service Act (relating to lower cost
3 plans), as added by title II of the Health Insurance Mar-
4 ketplace Modernization and Affordability Act of 2007.

5 “(c) DOMICILE AND NON-DOMICILE STATES.—

6 “(1) DOMICILE STATE.—Coverage shall be
7 issued to a small business health plan in the State
8 in which the sponsor’s principal place of business is
9 located.

10 “(2) NON-DOMICILE STATES.—With respect to
11 a State (other than the domicile State) in which par-
12 ticipating employers of a small business health plan
13 are located but in which the insurer of the small
14 business health plan in the domicile State is not yet
15 licensed, the following shall apply:

16 “(A) TEMPORARY PREEMPTION.—If, upon
17 the expiration of the 90-day period following
18 the submission of a licensure application by
19 such insurer (that includes a certified copy of
20 an approved licensure application as submitted
21 by such insurer in the domicile State) to such
22 State, such State has not approved or denied
23 such application, such State’s health insurance
24 licensure laws shall be temporarily preempted

1 and the insurer shall be permitted to operate in
2 such State, subject to the following terms:

3 “(i) APPLICATION OF NON-DOMICILE
4 STATE LAW.—Except with respect to licen-
5 sure and with respect to the terms of sub-
6 title A of title XXIX of the Public Health
7 Service Act (relating to rating and benefits
8 as added by the Health Insurance Market-
9 place Modernization and Affordability Act
10 of 2007), the laws and authority of the
11 non-domicile State shall remain in full
12 force and effect.

13 “(ii) REVOCATION OF PREEMPTION.—
14 The preemption of a non-domicile State’s
15 health insurance licensure laws pursuant to
16 this subparagraph, shall be terminated
17 upon the occurrence of either of the fol-
18 lowing:

19 “(I) APPROVAL OR DENIAL OF
20 APPLICATION.—The approval or denial
21 of an insurer’s licensure application,
22 following the laws and regulations of
23 the non-domicile State with respect to
24 licensure.

“(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2007)) of such State.

“(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

“(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part

1 shall be construed to limit the requirement that
2 insurers issuing coverage to small business
3 health plans shall be licensed in each State in
4 which the small business health plans operate.

5 “(D) SERVICING BY LICENSED INSUR-
6 ERS.—Notwithstanding subparagraph (C), the
7 requirements of this subsection may also be sat-
8 isfied if the participating employers of a small
9 business health plan are serviced by a licensed
10 insurer in that State, even where such insurer
11 is not the insurer of such small business health
12 plan in the State in which such small business
13 health plan is domiciled.

14 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
15 **LATED REQUIREMENTS.**

16 “(a) FILING FEE.—Under the procedure prescribed
17 pursuant to section 802(a), a small business health plan
18 shall pay to the applicable authority at the time of filing
19 an application for certification under this part a filing fee
20 in the amount of \$5,000, which shall be available in the
21 case of the Secretary, to the extent provided in appropria-
22 tion Acts, for the sole purpose of administering the certifi-
23 cation procedures applicable with respect to small business
24 health plans.

1 “(b) INFORMATION TO BE INCLUDED IN APPLICA-
2 TION FOR CERTIFICATION.—An application for certifi-
3 cation under this part meets the requirements of this sec-
4 tion only if it includes, in a manner and form which shall
5 be prescribed by the applicable authority by regulation, at
6 least the following information:

7 “(1) IDENTIFYING INFORMATION.—The names
8 and addresses of—

9 “(A) the sponsor; and

10 “(B) the members of the board of trustees
11 of the plan.

12 “(2) STATES IN WHICH PLAN INTENDS TO DO
13 BUSINESS.—The States in which participants and
14 beneficiaries under the plan are to be located and
15 the number of them expected to be located in each
16 such State.

17 “(3) BONDING REQUIREMENTS.—Evidence pro-
18 vided by the board of trustees that the bonding re-
19 quirements of section 412 will be met as of the date
20 of the application or (if later) commencement of op-
21 erations.

22 “(4) PLAN DOCUMENTS.—A copy of the docu-
23 ments governing the plan (including any bylaws and
24 trust agreements), the summary plan description,
25 and other material describing the benefits that will

1 be provided to participants and beneficiaries under
2 the plan.

3 “(5) AGREEMENTS WITH SERVICE PRO-
4 VIDERS.—A copy of any agreements between the
5 plan, health insurance issuer, and contract adminis-
6 trators and other service providers.

7 “(c) FILING NOTICE OF CERTIFICATION WITH
8 STATES.—A certification granted under this part to a
9 small business health plan shall not be effective unless
10 written notice of such certification is filed with the appli-
11 cable State authority of each State in which the small
12 business health plans operate.

13 “(d) NOTICE OF MATERIAL CHANGES.—In the case
14 of any small business health plan certified under this part,
15 descriptions of material changes in any information which
16 was required to be submitted with the application for the
17 certification under this part shall be filed in such form
18 and manner as shall be prescribed by the applicable au-
19 thority by regulation. The applicable authority may re-
20 quire by regulation prior notice of material changes with
21 respect to specified matters which might serve as the basis
22 for suspension or revocation of the certification.

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
2 **MINATION.**

3 “A small business health plan which is or has been
4 certified under this part may terminate (upon or at any
5 time after cessation of accruals in benefit liabilities) only
6 if the board of trustees, not less than 60 days before the
7 proposed termination date—

8 “(1) provides to the participants and bene-
9 ficiaries a written notice of intent to terminate stat-
10 ing that such termination is intended and the pro-
11 posed termination date;

12 “(2) develops a plan for winding up the affairs
13 of the plan in connection with such termination in
14 a manner which will result in timely payment of all
15 benefits for which the plan is obligated; and

16 “(3) submits such plan in writing to the appli-
17 cable authority.

18 Actions required under this section shall be taken in such
19 form and manner as may be prescribed by the applicable
20 authority by regulation.

21 **“SEC. 809. IMPLEMENTATION AND APPLICATION AUTHOR-**
22 **ITY BY SECRETARY.**

23 “The Secretary shall, through promulgation and im-
24 plementation of such regulations as the Secretary may
25 reasonably determine necessary or appropriate, and in
26 consultation with a balanced spectrum of effected entities

1 and persons, modify the implementation and application
2 of this part to accommodate with minimum disruption
3 such changes to State or Federal law provided in this part
4 and the Ten Steps to Transform Health Care in America
5 Act (and the amendments made by such Act) or in regula-
6 tions issued thereto.

7 **“SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.**

8 “(a) DEFINITIONS.—For purposes of this part—

9 “(1) AFFILIATED MEMBER.—The term ‘affili-
10 ated member’ means, in connection with a sponsor—

11 “(A) a person who is otherwise eligible to
12 be a member of the sponsor but who elects an
13 affiliated status with the sponsor, or

14 “(B) in the case of a sponsor with mem-
15 bers which consist of associations, a person who
16 is a member or employee of any such associa-
17 tion and elects an affiliated status with the
18 sponsor.

19 “(2) APPLICABLE AUTHORITY.—The term ‘ap-
20 plicable authority’ means the Secretary of Labor, ex-
21 cept that, in connection with any exercise of the Sec-
22 retary’s authority with respect to which the Sec-
23 retary is required under section 506(d) to consult
24 with a State, such term means the Secretary, in con-
25 sultation with such State.

“(3) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

“(4) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

“(5) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

“(6) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided in section 733(b)(2).

“(7) INDIVIDUAL MARKET.—

“(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

1 “(B) TREATMENT OF VERY SMALL
2 GROUPS.—

3 “(i) IN GENERAL.—Subject to clause
4 (ii), such term includes coverage offered in
5 connection with a group health plan that
6 has fewer than 2 participants as current
7 employees or participants described in sec-
8 tion 732(d)(3) on the first day of the plan
9 year.

10 “(ii) STATE EXCEPTION.—Clause (i)
11 shall not apply in the case of health insur-
12 ance coverage offered in a State if such
13 State regulates the coverage described in
14 such clause in the same manner and to the
15 same extent as coverage in the small group
16 market (as defined in section 2791(e)(5) of
17 the Public Health Service Act) is regulated
18 by such State.

19 “(8) MEDICAL CARE.—The term ‘medical care’
20 has the meaning provided in section 733(a)(2).

21 “(9) PARTICIPATING EMPLOYER.—The term
22 ‘participating employer’ means, in connection with a
23 small business health plan, any employer, if any in-
24 dividual who is an employee of such employer, a
25 partner in such employer, or a self-employed indi-

vidual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

“(10) SMALL EMPLOYER.—The term ‘small employer’ means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

“(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms ‘trade association’ and ‘professional association’ mean an entity that meets the requirements of section 1.501(c)(6)–1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

“(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

“(1) in the case of a partnership, the term ‘employer’ (as defined in section 3(5)) includes the partnership in relation to the partners, and the term

1 ‘employee’ (as defined in section 3(6)) includes any
2 partner in relation to the partnership; and

3 “(2) in the case of a self-employed individual,
4 the term ‘employer’ (as defined in section 3(5)) and
5 the term ‘employee’ (as defined in section 3(6)) shall
6 include such individual.

7 “(c) RENEWAL.—Notwithstanding any provision of
8 law to the contrary, a participating employer in a small
9 business health plan shall not be deemed to be a plan
10 sponsor in applying requirements relating to coverage re-
11 newal.

12 “(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this
13 part shall be construed to create any mandates for cov-
14 erage of benefits for HSA-qualified health plans that
15 would require reimbursements in violation of section
16 223(c)(2) of the Internal Revenue Code of 1986.”.

17 (b) CONFORMING AMENDMENTS TO PREEMPTION
18 RULES.—

19 (1) Section 514(b)(6) of such Act (29 U.S.C.
20 1144(b)(6)) is amended by adding at the end the
21 following new subparagraph:

22 “(E) The preceding subparagraphs of this paragraph
23 do not apply with respect to any State law in the case
24 of a small business health plan which is certified under
25 part 8.”.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (d)”;

(B) in subsection (b)(5), by striking “subsection (a)” in subparagraph (A) and inserting “subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

“(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.

“(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer op-

erating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007) (concerning health plan rating and benefits) are met.”.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: “Such term also includes a person serving as the sponsor of a small business health plan under part 8.”.

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting “or part 8” after “this part”.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

“PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

“801. Small business health plans.

“802. Alternative market pooling organizations.

“803. Certification of small business health plans.

“804. Requirements relating to sponsors and boards of trustees.

“805. Participation and coverage requirements.

“806. Other requirements relating to plan documents, contribution rates, and benefit options.

“807. Requirements for application and related requirements.

“808. Notice requirements for voluntary termination.

“809. Implementation and application authority by Secretary.

“810. Definitions and rules of construction.”.

1 **SEC. 246. COOPERATION BETWEEN FEDERAL AND STATE**
2 **AUTHORITIES.**

3 Section 506 of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
5 at the end the following new subsection:

6 “(d) CONSULTATION WITH STATES WITH RESPECT
7 TO SMALL BUSINESS HEALTH PLANS.—

8 “(1) AGREEMENTS WITH STATES.—The Sec-
9 retary shall consult with the State recognized under
10 paragraph (2) with respect to a small business
11 health plan regarding the exercise of—

12 “(A) the Secretary’s authority under sec-
13 tions 502 and 504 to enforce the requirements
14 for certification under part 8; and

15 “(B) the Secretary’s authority to certify
16 small business health plans under part 8 in ac-
17 cordance with regulations of the Secretary ap-
18 plicable to certification under part 8.

19 “(2) RECOGNITION OF DOMICILE STATE.—In
20 carrying out paragraph (1), the Secretary shall en-
21 sure that only one State will be recognized, with re-
22 spect to any particular small business health plan,
23 as the State with which consultation is required. In
24 carrying out this paragraph such State shall be the
25 domicile State, as defined in section 805(c).”.

1 **SEC. 247. EFFECTIVE DATE AND TRANSITIONAL AND**
2 **OTHER RULES.**

3 (a) **EFFECTIVE DATE.**—The amendments made by
4 this subtitle shall take effect 12 months after the date of
5 the enactment of this Act. The Secretary of Labor shall
6 first issue all regulations necessary to carry out the
7 amendments made by this subtitle within 6 months after
8 the date of the enactment of this Act.

9 (b) **TREATMENT OF CERTAIN EXISTING HEALTH**
10 **BENEFITS PROGRAMS.**—

11 (1) **IN GENERAL.**—In any case in which, as of
12 the date of the enactment of this Act, an arrange-
13 ment is maintained in a State for the purpose of
14 providing benefits consisting of medical care for the
15 employees and beneficiaries of its participating em-
16 ployers, at least 200 participating employers make
17 contributions to such arrangement, such arrange-
18 ment has been in existence for at least 10 years, and
19 such arrangement is licensed under the laws of one
20 or more States to provide such benefits to its par-
21 ticipating employers, upon the filing with the appli-
22 cable authority (as defined in section 808(a)(2) of
23 the Employee Retirement Income Security Act of
24 1974 (as amended by this subtitle)) by the arrange-
25 ment of an application for certification of the ar-

1 arrangement under part 8 of subtitle B of title I of
2 such Act—

3 (A) such arrangement shall be deemed to
4 be a group health plan for purposes of title I
5 of such Act;

6 (B) the requirements of sections 801(a)
7 and 803(a) of the Employee Retirement Income
8 Security Act of 1974 shall be deemed met with
9 respect to such arrangement;

10 (C) the requirements of section 803(b) of
11 such Act shall be deemed met, if the arrange-
12 ment is operated by a board of trustees which
13 has control over the arrangement;

14 (D) the requirements of section 804(a) of
15 such Act shall be deemed met with respect to
16 such arrangement; and

17 (E) the arrangement may be certified by
18 any applicable authority with respect to its op-
19 erations in any State only if it operates in such
20 State on the date of certification.

21 The provisions of this subsection shall cease to apply
22 with respect to any such arrangement at such time
23 after the date of the enactment of this Act as the
24 applicable requirements of this subsection are not
25 met with respect to such arrangement or at such

time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms “group health plan”, “medical care”, and “participating employer” shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an “small business health plan” shall be deemed a reference to an arrangement referred to in this subsection.

PART II—MARKET RELIEF

SEC. 251. MARKET RELIEF.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

“TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

“SEC. 2901. GENERAL INSURANCE DEFINITIONS.

“In this title, the terms ‘health insurance coverage’, ‘health insurance issuer’, ‘group health plan’, and ‘individual health insurance’ shall have the meanings given such terms in section 2791.

1 **“SEC. 2902. IMPLEMENTATION AND APPLICATION AUTHOR-**
2 **ITY BY SECRETARY.**

3 “The Secretary shall, through promulgation and im-
4 plementation of such regulations as the Secretary may
5 reasonably determine necessary or appropriate, and in
6 consultation with a balanced spectrum of effected entities
7 and persons, modify the implementation and application
8 of this title to accommodate with minimum disruption
9 such changes to State or Federal law provided in this title
10 and the Ten Steps to Transform Health Care in America
11 Act (and the amendments made by such Act) or in regula-
12 tions issued thereto.

13 **“Subtitle A—Market Relief**

14 **“PART I—RATING REQUIREMENTS**

15 **“SEC. 2911. DEFINITIONS.**

16 “In this part:

17 “(1) **ADOPTING STATE.**—The term ‘adopting
18 State’ means a State that, with respect to the small
19 group market, has enacted small group rating rules
20 that meet the minimum standards set forth in sec-
21 tion 2912(a)(1) or, as applicable, transitional small
22 group rating rules set forth in section 2912(b).

23 “(2) **APPLICABLE STATE AUTHORITY.**—The
24 term ‘applicable State authority’ means, with respect
25 to a health insurance issuer in a State, the State in-
26 surance commissioner or official or officials des-

1 ignated by the State to enforce the insurance laws
2 of such State.

3 “(3) BASE PREMIUM RATE.—The term ‘base
4 premium rate’ means, for each class of business with
5 respect to a rating period, the lowest premium rate
6 charged or that could have been charged under a
7 rating system for that class of business by the small
8 employer carrier to small employers with similar
9 case characteristics for health benefit plans with the
10 same or similar coverage

11 “(4) ELIGIBLE INSURER.—The term ‘eligible
12 insurer’ means a health insurance issuer that is li-
13 censed in a State and that—

14 “(A) notifies the Secretary, not later than
15 30 days prior to the offering of coverage de-
16 scribed in this subparagraph, that the issuer in-
17 tends to offer health insurance coverage con-
18 sistent with the Model Small Group Rating
19 Rules or, as applicable, transitional small group
20 rating rules in a State;

21 “(B) notifies the insurance department of
22 a nonadopting State (or other State agency),
23 not later than 30 days prior to the offering of
24 coverage described in this subparagraph, that
25 the issuer intends to offer small group health

insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

“(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer’s contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

“(5) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

“(6) INDEX RATE.—The term ‘index rate’ means for each class of business with respect to the

1 rating period for small employers with similar case
2 characteristics, the arithmetic average of the appli-
3 cable base premium rate and the corresponding
4 highest premium rate.

5 “(7) MODEL SMALL GROUP RATING RULES.—
6 The term ‘Model Small Group Rating Rules’ means
7 the rules set forth in section 2912(a)(2).

8 “(8) NONADOPTING STATE.—The term ‘non-
9 adopting State’ means a State that is not an adopt-
10 ing State.

11 “(9) SMALL GROUP INSURANCE MARKET.—The
12 term ‘small group insurance market’ shall have the
13 meaning given the term ‘small group market’ in sec-
14 tion 2791(e)(5).

15 “(10) STATE LAW.—The term ‘State law’
16 means all laws, decisions, rules, regulations, or other
17 State actions (including actions by a State agency)
18 having the effect of law, of any State.

19 “(11) VARIATION LIMITS.—

20 “(A) COMPOSITE VARIATION LIMIT.—

21 “(i) IN GENERAL.—The term ‘com-
22 posite variation limit’ means the total vari-
23 ation in premium rates charged by a
24 health insurance issuer in the small group
25 market as permitted under applicable State

law based on the following factors or case characteristics:

“(I) Age.

“(II) Duration of coverage.

“(III) Claims experience.

“(IV) Health status.

“(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

“(B) TOTAL VARIATION LIMIT.—The term ‘total variation limit’ means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 2912(a)(1)).

“SEC. 2912. RATING RULES.

“(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of

1 enactment of this title, the Secretary shall promulgate reg-
2 ulations establishing the following Minimum Standards
3 and Model Small Group Rating Rules:

4 “(1) MINIMUM STANDARDS FOR PREMIUM VARI-
5 ATIONS.—

6 “(A) COMPOSITE VARIATION LIMIT.—The
7 composite variation limit shall not be less than
8 3:1.

9 “(B) TOTAL VARIATION LIMIT.—The total
10 variation limit shall not be less than 5:1.

11 “(C) PROHIBITION ON USE OF CERTAIN
12 CASE CHARACTERISTICS.—For purposes of this
13 paragraph, in calculating the total variation
14 limit, the State shall not use case characteris-
15 tics other than those used in calculating the
16 composite variation limit and industry, geo-
17 graphic area, group size, participation rate,
18 class of business, and participation in wellness
19 programs.

20 “(2) MODEL SMALL GROUP RATING RULES.—
21 The following apply to an eligible insurer in a non-
22 adopting State:

23 “(A) PREMIUM RATES.—Premium rates
24 for small group health benefit plans to which
25 this title applies shall comply with the following

provisions relating to premiums, except as provided for under subsection (b):

“(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

“(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

“(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

“(iv) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the

premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

“(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

“(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than 1 year, due to the claim experience, health status or duration of cov-

1 erage of the employees or dependents
2 of the small employer as determined
3 from the small employer carrier's rate
4 manual for the class of business in-
5 volved.

6 “(III) Any adjustment due to
7 change in coverage or change in the
8 case characteristics of the small em-
9 ployer as determined from the small
10 employer carrier's rate manual for the
11 class of business.

12 “(v) UNIFORM APPLICATION OF AD-
13 JUSTMENTS.—Adjustments in premium
14 rates for claim experience, health status, or
15 duration of coverage shall not be charged
16 to individual employees or dependents. Any
17 such adjustment shall be applied uniformly
18 to the rates charged for all employees and
19 dependents of the small employer.

20 “(vi) PROHIBITION ON USE OF CER-
21 TAIN CASE CHARACTERISTIC.—A small em-
22 ployer carrier shall not utilize case charac-
23 teristics, other than those permitted under
24 paragraph (1)(C), without the prior ap-
25 proval of the applicable State authority.

1 “(vii) CONSISTENT APPLICATION OF
2 FACTORS.—Small employer carriers shall
3 apply rating factors, including case charac-
4 teristics, consistently with respect to all
5 small employers in a class of business.
6 Rating factors shall produce premiums for
7 identical groups which differ only by the
8 amounts attributable to plan design and do
9 not reflect differences due to the nature of
10 the groups assumed to select particular
11 health benefit plans.

12 “(viii) TREATMENT OF PLANS AS HAV-
13 ING SAME RATING PERIOD.—A small em-
14 ployer carrier shall treat all health benefit
15 plans issued or renewed in the same cal-
16 endar month as having the same rating pe-
17 riod.

18 “(ix) REQUIRE COMPLIANCE.—Pre-
19 mium rates for small business health ben-
20 efit plans shall comply with the require-
21 ments of this subsection notwithstanding
22 any assessments paid or payable by a small
23 employer carrier as required by a State’s
24 small employer carrier reinsurance pro-
25 gram.

1 “(B) ESTABLISHMENT OF SEPARATE
2 CLASS OF BUSINESS.—Subject to subparagraph
3 (C), a small employer carrier may establish a
4 separate class of business only to reflect sub-
5 stantial differences in expected claims experi-
6 ence or administrative costs related to the fol-
7 lowing:

8 “(i) The small employer carrier uses
9 more than one type of system for the mar-
10 keting and sale of health benefit plans to
11 small employers.

12 “(ii) The small employer carrier has
13 acquired a class of business from another
14 small employer carrier.

15 “(iii) The small employer carrier pro-
16 vides coverage to one or more association
17 groups that meet the requirements of this
18 title.

19 “(C) LIMITATION.—A small employer car-
20 rier may establish up to 9 separate classes of
21 business under subparagraph (B), excluding
22 those classes of business related to association
23 groups under this title.

24 “(D) LIMITATION ON TRANSFERS.—A
25 small employer carrier shall not transfer a

1 small employer involuntarily into or out of a
2 class of business. A small employer carrier shall
3 not offer to transfer a small employer into or
4 out of a class of business unless such offer is
5 made to transfer all small employers in the
6 class of business without regard to case charac-
7 teristics, claim experience, health status or du-
8 ration of coverage since issue.

9 “(b) TRANSITIONAL MODEL SMALL GROUP RATING
10 RULES.—

11 “(1) IN GENERAL.—Not later than 6 months
12 after the date of enactment of this title and to the
13 extent necessary to provide for a graduated transi-
14 tion to the minimum standards for premium vari-
15 ation as provided for in subsection (a)(1), the Sec-
16 retary, in consultation with the National Association
17 of Insurance Commissioners (NAIC), shall promul-
18 gate State-specific transitional small group rating
19 rules in accordance with this subsection, which shall
20 be applicable with respect to non-adopting States
21 and eligible insurers operating in such States for a
22 period of not to exceed 3 years from the date of the
23 promulgation of the minimum standards for pre-
24 mium variation pursuant to subsection (a).

“(2) COMPLIANCE WITH TRANSITIONAL MODEL
SMALL GROUP RATING RULES.—During the transi-
tion period described in paragraph (1), a State that,
on the date of enactment of this title, has in effect
a small group rating rules methodology that allows
for a variation that is less than the variation pro-
vided for under subsection (a)(1) (concerning min-
imum standards for premium variation), shall be
deemed to be an adopting State if the State complies
with the transitional small group rating rules as pro-
mulgated by the Secretary pursuant to paragraph
(1).

“(3) TRANSITIONING OF OLD BUSINESS.—

“(A) IN GENERAL.—In developing the
transitional small group rating rules under
paragraph (1), the Secretary shall, after con-
sultation with the National Association of In-
surance Commissioners and representatives of
insurers operating in the small group health in-
surance market in non-adopting States, promul-
gate special transition standards with respect to
independent rating classes for old and new busi-
ness, to the extent reasonably necessary to pro-
tect health insurance consumers and to ensure

1 a stable and fair transition for old and new
2 market entrants.

3 “(B) PERIOD FOR OPERATION OF INDE-
4 PENDENT RATING CLASSES.—In developing the
5 special transition standards pursuant to sub-
6 paragraph (A), the Secretary shall permit a
7 carrier in a non-adopting State, at its option, to
8 maintain independent rating classes for old and
9 new business for a period of up to 5 years, with
10 the commencement of such 5-year period to
11 begin at such time, but not later than the date
12 that is 3 years after the date of enactment of
13 this title, as the carrier offers a book of busi-
14 ness meeting the minimum standards for pre-
15 mium variation provided for in subsection
16 (a)(1) or the transitional small group rating
17 rules under paragraph (1).

18 “(4) OTHER TRANSITIONAL AUTHORITY.—In
19 developing the transitional small group rating rules
20 under paragraph (1), the Secretary shall provide for
21 the application of the transitional small group rating
22 rules in transition States as the Secretary may de-
23 termine necessary for a an effective transition.

24 “(c) MARKET RE-ENTRY.—

1 “(1) IN GENERAL.—Notwithstanding any other
2 provision of law, a health insurance issuer that has
3 voluntarily withdrawn from providing coverage in the
4 small group market prior to the date of enactment
5 of the Health Insurance Marketplace Modernization
6 and Affordability Act of 2007 shall not be excluded
7 from re-entering such market on a date that is more
8 than 180 days after such date of enactment.

9 “(2) TERMINATION.—The provision of this sub-
10 section shall terminate on the date that is 24
11 months after the date of enactment of the Health
12 Insurance Marketplace Modernization and Afford-
13 ability Act of 2007.

14 **“SEC. 2913. APPLICATION AND PREEMPTION.**

15 “(a) SUPERSEDING OF STATE LAW.—

16 “(1) IN GENERAL.—This part shall supersede
17 any and all State laws of a non-adopting State inso-
18 far as such State laws (whether enacted prior to or
19 after the date of enactment of this subtitle) relate to
20 rating in the small group insurance market as ap-
21 plied to an eligible insurer, or small group health in-
22 surance coverage issued by an eligible insurer, in-
23 cluding with respect to coverage issued to a small
24 employer through a small business health plan, in a
25 State.

1 “(2) NONADOPTING STATES.—This part shall
2 supersede any and all State laws of a nonadopting
3 State insofar as such State laws (whether enacted
4 prior to or after the date of enactment of this sub-
5 title)—

6 “(A) prohibit an eligible insurer from of-
7 fering, marketing, or implementing small group
8 health insurance coverage consistent with the
9 Model Small Group Rating Rules or transitional
10 model small group rating rules; or

11 “(B) have the effect of retaliating against
12 or otherwise punishing in any respect an eligible
13 insurer for offering, marketing, or imple-
14 menting small group health insurance coverage
15 consistent with the Model Small Group Rating
16 Rules or transitional model small group rating
17 rules.

18 “(b) SAVINGS CLAUSE AND CONSTRUCTION.—

19 “(1) NONAPPLICATION TO ADOPTING STATES.—
20 Subsection (a) shall not apply with respect to adopt-
21 ing states.

22 “(2) NONAPPLICATION TO CERTAIN INSUR-
23 ERS.—Subsection (a) shall not apply with respect to
24 insurers that do not qualify as eligible insurers that

offer small group health insurance coverage in a nonadopting State.

“(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

“(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

“(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

1 “(c) EFFECTIVE DATE.—This section shall apply, at
2 the election of the eligible insurer, beginning in the first
3 plan year or the first calendar year following the issuance
4 of the final rules by the Secretary under the Model Small
5 Group Rating Rules or, as applicable, the Transitional
6 Model Small Group Rating Rules, but in no event earlier
7 than the date that is 12 months after the date of enact-
8 ment of this title.

9 **“SEC. 2914. CIVIL ACTIONS AND JURISDICTION.**

10 “(a) IN GENERAL.—The courts of the United States
11 shall have exclusive jurisdiction over civil actions involving
12 the interpretation of this part.

13 “(b) ACTIONS.—An eligible insurer may bring an ac-
14 tion in the district courts of the United States for injunc-
15 tive or other equitable relief against any officials or agents
16 of a nonadopting State in connection with any conduct or
17 action, or proposed conduct or action, by such officials or
18 agents which violates, or which would if undertaken vio-
19 late, section 2913.

20 “(c) DIRECT FILING IN COURT OF APPEALS.—At the
21 election of the eligible insurer, an action may be brought
22 under subsection (b) directly in the United States Court
23 of Appeals for the circuit in which the nonadopting State
24 is located by the filing of a petition for review in such
25 Court.

1 “(d) EXPEDITED REVIEW.—

2 “(1) DISTRICT COURT.—In the case of an ac-
3 tion brought in a district court of the United States
4 under subsection (b), such court shall complete such
5 action, including the issuance of a judgment, prior
6 to the end of the 120-day period beginning on the
7 date on which such action is filed, unless all parties
8 to such proceeding agree to an extension of such pe-
9 riod.

10 “(2) COURT OF APPEALS.—In the case of an
11 action brought directly in a United States Court of
12 Appeal under subsection (c), or in the case of an ap-
13 peal of an action brought in a district court under
14 subsection (b), such Court shall complete all action
15 on the petition, including the issuance of a judg-
16 ment, prior to the end of the 60-day period begin-
17 ning on the date on which such petition is filed with
18 the Court, unless all parties to such proceeding
19 agree to an extension of such period.

20 “(e) STANDARD OF REVIEW.—A court in an action
21 filed under this section, shall render a judgment based on
22 a review of the merits of all questions presented in such
23 action and shall not defer to any conduct or action, or
24 proposed conduct or action, of a nonadopting State.

1 **“SEC. 2915. ONGOING REVIEW.**

2 “Not later than 5 years after the date on which the
3 Model Small Group Rating Rules are issued under this
4 part, and every 5 years thereafter, the Secretary, in con-
5 sultation with the National Association of Insurance Com-
6 missioners, shall prepare and submit to the appropriate
7 committees of Congress a report that assesses the effect
8 of the Model Small Group Rating Rules on access, cost,
9 and market functioning in the small group market. Such
10 report may, if the Secretary, in consultation with the Na-
11 tional Association of Insurance Commissioners, deter-
12 mines such is appropriate for improving access, costs, and
13 market functioning, contain legislative proposals for rec-
14 ommended modification to such Model Small Group Rat-
15 ing Rules.

16 **“PART II—AFFORDABLE PLANS**

17 **“SEC. 2921. DEFINITIONS.**

18 “In this part:

19 “(1) **ADOPTING STATE.**—The term ‘adopting
20 State’ means a State that has enacted a law pro-
21 viding that small group, individual, and large group
22 health insurers in such State may offer and sell
23 products in accordance with the List of Required
24 Benefits and the Terms of Application as provided
25 for in section 2922(b)

1 “(2) ELIGIBLE INSURER.—The term ‘eligible
2 insurer’ means a health insurance issuer that is li-
3 censed in a nonadopting State and that—

4 “(A) notifies the Secretary, not later than
5 30 days prior to the offering of coverage de-
6 scribed in this subparagraph, that the issuer in-
7 tends to offer health insurance coverage con-
8 sistent with the List of Required Benefits and
9 Terms of Application in a nonadopting State;

10 “(B) notifies the insurance department of
11 a nonadopting State (or other applicable State
12 agency), not later than 30 days prior to the of-
13 fering of coverage described in this subpara-
14 graph, that the issuer intends to offer health in-
15 surance coverage in that State consistent with
16 the List of Required Benefits and Terms of Ap-
17 plication, and provides with such notice a copy
18 of any insurance policy that it intends to offer
19 in the State, its most recent annual and quar-
20 terly financial reports, and any other informa-
21 tion required to be filed with the insurance de-
22 partment of the State (or other State agency)
23 by the Secretary in regulations; and

24 “(C) includes in the terms of the health in-
25 surance coverage offered in nonadopting States

(including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the List of Required Benefits and a description of the Terms of Application, including a description of the benefits to be provided, and that adherence to such standards is included as a term of such contract.

“(3) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ means any coverage issued in the small group, individual, or large group health insurance markets, including with respect to small business health plans, except that such term shall not include excepted benefits (as defined in section 2791(c)).

“(4) LIST OF REQUIRED BENEFITS.—The term ‘List of Required Benefits’ means the List issued under section 2922(a).

“(5) NONADOPTING STATE.—The term ‘non-adopting State’ means a State that is not an adopting State.

“(6) STATE LAW.—The term ‘State law’ means all laws, decisions, rules, regulations, or other State

actions (including actions by a State agency) having the effect of law, of any State.

“(7) STATE PROVIDER FREEDOM OF CHOICE LAW.—The term ‘State Provider Freedom of Choice Law’ means a State law requiring that a health insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law.

“(8) TERMS OF APPLICATION.—The term ‘Terms of Application’ means terms provided under section 2922(a).

“SEC. 2922. OFFERING AFFORDABLE PLANS.

“(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the ‘List of Required Benefits’) of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group, individual, and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through

1 small business health plans, the List of Required Benefits
2 applicable to the small group market shall apply.

3 “(b) TERMS OF APPLICATION.—

4 “(1) STATE WITH MANDATES.—With respect to
5 a State that has a covered benefit, service, or cat-
6 egory of provider mandate in effect that is covered
7 under the List of Required Benefits under sub-
8 section (a), such State mandate shall, subject to
9 paragraph (3) (concerning uniform application),
10 apply to a coverage plan or plan in, as applicable,
11 the small group, individual, or large group market or
12 through a small business health plan in such State.

13 “(2) STATES WITHOUT MANDATES.—With re-
14 spect to a State that does not have a covered ben-
15 efit, service, or category of provider mandate in ef-
16 fect that is covered under the List of Required Ben-
17 efits under subsection (a), such mandate shall not
18 apply, as applicable, to a coverage plan or plan in
19 the small group, individual, or large group market or
20 through a small business health plan in such State.

21 “(3) UNIFORM APPLICATION OF LAWS.—

22 “(A) IN GENERAL.—With respect to a
23 State described in paragraph (1), in applying a
24 covered benefit, service, or category of provider
25 mandate that is on the List of Required Bene-

fits under subsection (a) the State shall permit a coverage plan or plan offered in the small group, individual, or large group market or through a small business health plan in such State to apply such benefit, service, or category of provider coverage in a manner consistent with the manner in which such coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code (as determined by the Secretary in consultation with the Director of the Office of Personnel Management), and consistent with the Publication of Benefit Applications under subsection (c). In the event a covered benefit, service, or category of provider appearing in the List of Required Benefits is not offered in one of the three most heavily subscribed national health plans offered under the Federal Employees Health Benefits Program, such covered benefit, service, or category of provider requirement shall be applied in a manner consistent with the manner in which such coverage is offered in the remaining most heavily subscribed plan of the

1 remaining Federal Employees Health Benefits
2 Program plans, as determined by the Secretary,
3 in consultation with the Director of the Office
4 of Personnel Management.

5 “(B) EXCEPTION REGARDING STATE PRO-
6 VIDER FREEDOM OF CHOICE LAWS.—Notwith-
7 standing subparagraph (A), in the event a cat-
8 egory of provider mandate is included in the
9 List of Covered Benefits, any State Provider
10 Freedom of Choice Law (as defined in section
11 2921(7)) that is in effect in any State in which
12 such category of provider mandate is in effect
13 shall not be preempted, with respect to that cat-
14 egory of provider, by this part.

15 “(c) PUBLICATION OF BENEFIT APPLICATIONS.—
16 Not later than 3 months after the date of enactment of
17 this title, and on the first day of every calendar year there-
18 after, the Secretary, in consultation with the Director of
19 the Office of Personnel Management, shall publish in the
20 Federal Register a description of such covered benefits,
21 services, and categories of providers covered in that cal-
22 endar year by each of the three most heavily subscribed
23 nationally available Federal Employee Health Benefits
24 Plan options which are also included on the List of Re-
25 quired Benefits.

“(d) EFFECTIVE DATES.—

“(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

“(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

“(e) UPDATING OF LIST OF REQUIRED BENEFITS.—

Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.

“SEC. 2923. APPLICATION AND PREEMPTION.

“(a) SUPERCEDING OF STATE LAW.—

1 “(1) IN GENERAL.—This part shall supersede
2 any and all State laws insofar as such laws relate to
3 mandates relating to covered benefits, services, or
4 categories of provider in the health insurance market
5 as applied to an eligible insurer, or health insurance
6 coverage issued by an eligible insurer, including with
7 respect to coverage issued to a small business health
8 plan, in a nonadopting State.

9 “(2) NONADOPTING STATES.—This part shall
10 supersede any and all State laws of a nonadopting
11 State (whether enacted prior to or after the date of
12 enactment of this title) insofar as such laws—

13 “(A) prohibit an eligible insurer from of-
14 fering, marketing, or implementing health in-
15 surance coverage consistent with the Benefit
16 Choice Standards, as provided for in section
17 2922(a); or

18 “(B) have the effect of retaliating against
19 or otherwise punishing in any respect an eligible
20 insurer for offering, marketing, or imple-
21 menting health insurance coverage consistent
22 with the Benefit Choice Standards.

23 “(b) SAVINGS CLAUSE AND CONSTRUCTION.—

1 “(1) NONAPPLICATION TO ADOPTING STATES.—

2 Subsection (a) shall not apply with respect to adopt-
3 ing States.

4 “(2) NONAPPLICATION TO CERTAIN INSUR-

5 ERS.—Subsection (a) shall not apply with respect to
6 insurers that do not qualify as eligible insurers who
7 offer health insurance coverage in a nonadopting
8 State.

9 “(3) NONAPPLICATION WHERE OBTAINING RE-

10 LIEF UNDER STATE LAW.—Subsection (a)(1) shall
11 not supercede any State law of a nonadopting State
12 to the extent necessary to permit individuals or the
13 insurance department of the State (or other State
14 agency) to obtain relief under State law to require
15 an eligible insurer to comply with the Benefit Choice
16 Standards.

17 “(4) NO EFFECT ON PREEMPTION.—In no case

18 shall this part be construed to limit or affect in any
19 manner the preemptive scope of sections 502 and
20 514 of the Employee Retirement Income Security
21 Act of 1974. In no case shall this part be construed
22 to create any cause of action under Federal or State
23 law or enlarge or affect any remedy available under
24 the Employee Retirement Income Security Act of
25 1974.

1 “(5) PREEMPTION LIMITED TO BENEFITS.—

2 Subsection (a) shall not preempt any State law that
3 does not have a reference to or a connection with
4 State mandates regarding covered benefits, services,
5 or categories of providers that would otherwise apply
6 to eligible insurers.

7 **“SEC. 2924. CIVIL ACTIONS AND JURISDICTION.**

8 “(a) IN GENERAL.—The courts of the United States
9 shall have exclusive jurisdiction over civil actions involving
10 the interpretation of this part.

11 “(b) ACTIONS.—An eligible insurer may bring an ac-
12 tion in the district courts of the United States for injunc-
13 tive or other equitable relief against any officials or agents
14 of a nonadopting State in connection with any conduct or
15 action, or proposed conduct or action, by such officials or
16 agents which violates, or which would if undertaken vio-
17 late, section 2923.

18 “(c) DIRECT FILING IN COURT OF APPEALS.—At the
19 election of the eligible insurer, an action may be brought
20 under subsection (b) directly in the United States Court
21 of Appeals for the circuit in which the nonadopting State
22 is located by the filing of a petition for review in such
23 Court.

24 “(d) EXPEDITED REVIEW.—

“(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

“(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

“(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

1 **“SEC. 2925. RULES OF CONSTRUCTION.**

2 “(a) IN GENERAL.—Notwithstanding any other pro-
3 vision of Federal or State law, a health insurance issuer
4 in an adopting State or an eligible insurer in a non-adopt-
5 ing State may amend its existing policies to be consistent
6 with the terms of this subtitle (concerning rating and ben-
7 efits).

8 “(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this
9 subtitle shall be construed to create any mandates for cov-
10 erage of benefits for HSA-qualified health plans that
11 would require reimbursements in violation of section
12 223(c)(2) of the Internal Revenue Code of 1986.”.

13 **PART III—HARMONIZATION OF HEALTH**
14 **INSURANCE STANDARDS**

15 **SEC. 261. HEALTH INSURANCE STANDARDS HARMONI-**
16 **ZATION.**

17 Title XXIX of the Public Health Service Act (as
18 added by section 201) is amended by adding at the end
19 the following:

20 **“Subtitle B—Standards**
21 **Harmonization**

22 **“SEC. 2931. DEFINITIONS.**

23 “In this subtitle:

24 “(1) ADOPTING STATE.—The term ‘adopting
25 State’ means a State that has enacted the har-
26 monized standards adopted under this subtitle in

1 their entirety and as the exclusive laws of the State
2 that relate to the harmonized standards.

3 “(2) ELIGIBLE INSURER.—The term ‘eligible
4 insurer’ means a health insurance issuer that is li-
5 censed in a nonadopting State and that—

6 “(A) notifies the Secretary, not later than
7 30 days prior to the offering of coverage de-
8 scribed in this subparagraph, that the issuer in-
9 tends to offer health insurance coverage con-
10 sistent with the harmonized standards in a non-
11 adopting State;

12 “(B) notifies the insurance department of
13 a nonadopting State (or other State agency),
14 not later than 30 days prior to the offering of
15 coverage described in this subparagraph, that
16 the issuer intends to offer health insurance cov-
17 erage in that State consistent with the har-
18 monized standards published pursuant to sec-
19 tion 2933(d), and provides with such notice a
20 copy of any insurance policy that it intends to
21 offer in the State, its most recent annual and
22 quarterly financial reports, and any other infor-
23 mation required to be filed with the insurance
24 department of the State (or other State agency)
25 by the Secretary in regulations; and

1 “(C) includes in the terms of the health in-
2 surance coverage offered in nonadopting States
3 (including in the terms of any individual certifi-
4 cates that may be offered to individuals in con-
5 nection with such health coverage) and filed
6 with the State pursuant to subparagraph (B), a
7 description of the harmonized standards pub-
8 lished pursuant to section 2933(g)(2) and an
9 affirmation that such standards are a term of
10 the contract.

11 “(3) HARMONIZED STANDARDS.—The term
12 ‘harmonized standards’ means the standards cer-
13 tified by the Secretary under section 2933(d).

14 “(4) HEALTH INSURANCE COVERAGE.—The
15 term ‘health insurance coverage’ means any coverage
16 issued in the health insurance market, except that
17 such term shall not include excepted benefits (as de-
18 fined in section 2791(c).

19 “(5) NONADOPTING STATE.—The term ‘non-
20 adopting State’ means a State that fails to enact,
21 within 18 months of the date on which the Secretary
22 certifies the harmonized standards under this sub-
23 title, the harmonized standards in their entirety and
24 as the exclusive laws of the State that relate to the
25 harmonized standards.

“(6) STATE LAW.—The term ‘State law’ means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

“SEC. 2932. HARMONIZED STANDARDS.

“(a) BOARD.—

“(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the ‘Board’) to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

“(2) COMPOSITION.—

“(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

“(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be

1 Republicans, and of which one shall be des-
2 ignated as the chairperson and one shall be
3 designated as the vice chairperson.

4 “(ii) Four representatives of State
5 government, two of which shall be gov-
6 ernors of States and two of which shall be
7 State legislators, and two of which shall be
8 Democrats and two of which shall be Re-
9 publicans.

10 “(iii) Four representatives of health
11 insurers, of which one shall represent in-
12 surers that offer coverage in the small
13 group market, one shall represent insurers
14 that offer coverage in the large group mar-
15 ket, one shall represent insurers that offer
16 coverage in the individual market, and one
17 shall represent carriers operating in a re-
18 gional market.

19 “(iv) Two representatives of insurance
20 agents and brokers.

21 “(v) Two independent representatives
22 of the American Academy of Actuaries who
23 have familiarity with the actuarial methods
24 applicable to health insurance.

1 “(B) EX OFFICIO MEMBER.—A representa-
2 tive of the Secretary shall serve as an ex officio
3 member of the Board.

4 “(3) ADVISORY PANEL.—The Secretary shall
5 establish an advisory panel to provide advice to the
6 Board, and shall appoint its members after consid-
7 ering the recommendations of professional organiza-
8 tions representing the entities and constituencies
9 identified in this paragraph:

10 “(A) Two representatives of small business
11 health plans.

12 “(B) Two representatives of employers, of
13 which one shall represent small employers and
14 one shall represent large employers.

15 “(C) Two representatives of consumer or-
16 ganizations.

17 “(D) Two representatives of health care
18 providers.

19 “(4) QUALIFICATIONS.—The membership of the
20 Board shall include individuals with national rec-
21 ognition for their expertise in health finance and ec-
22 onomics, actuarial science, health plans, providers of
23 health services, and other related fields, who provide
24 a mix of different professionals, broad geographic

1 representation, and a balance between urban and
2 rural representatives.

3 “(5) ETHICAL DISCLOSURE.—The Secretary
4 shall establish a system for public disclosure by
5 members of the Board of financial and other poten-
6 tial conflicts of interest relating to such members.
7 Members of the Board shall be treated as employees
8 of Congress for purposes of applying title I of the
9 Ethics in Government Act of 1978 (Public Law 95–
10 521).

11 “(6) DIRECTOR AND STAFF.—Subject to such
12 review as the Secretary deems necessary to assure
13 the efficient administration of the Board, the chair
14 and vice-chair of the Board may—

15 “(A) employ and fix the compensation of
16 an Executive Director (subject to the approval
17 of the Comptroller General) and such other per-
18 sonnel as may be necessary to carry out its du-
19 ties (without regard to the provisions of title 5,
20 United States Code, governing appointments in
21 the competitive service);

22 “(B) seek such assistance and support as
23 may be required in the performance of its du-
24 ties from appropriate Federal departments and
25 agencies;

“(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

“(D) make advance, progress, and other payments which relate to the work of the Board;

“(E) provide transportation and subsistence for persons serving without compensation; and

“(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

“(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

“(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

“(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized

1 standards for each of the following process cat-
2 egories:

3 “(A) FORM FILING AND RATE FILING.—

4 Form and rate filing standards shall be estab-
5 lished which promote speed to market and in-
6 clude the following defined areas for States that
7 require such filings:

8 “(i) Procedures for form and rate fil-
9 ing pursuant to a streamlined administra-
10 tive filing process.

11 “(ii) Timeframes for filings to be re-
12 viewed by a State if review is required be-
13 fore they are deemed approved.

14 “(iii) Timeframes for an eligible in-
15 surer to respond to State requests fol-
16 lowing its review.

17 “(iv) A process for an eligible insurer
18 to self-certify.

19 “(v) State development of form and
20 rate filing templates that include only non-
21 preempted State law and Federal law re-
22 quirements for eligible insurers with timely
23 updates.

24 “(vi) Procedures for the resubmission
25 of forms and rates.

1 “(vii) Disapproval rationale of a form
2 or rate filing based on material omissions
3 or violations of non-preempted State law or
4 Federal law with violations cited and ex-
5 plained.

6 “(viii) For States that may require a
7 hearing, a rationale for hearings based on
8 violations of non-preempted State law or
9 insurer requests.

10 “(B) MARKET CONDUCT REVIEW.—Market
11 conduct review standards shall be developed
12 which provide for the following:

13 “(i) Mandatory participation in na-
14 tional databases.

15 “(ii) The confidentiality of examina-
16 tion materials.

17 “(iii) The identification of the State
18 agency with primary responsibility for ex-
19 aminations.

20 “(iv) Consultation and verification of
21 complaint data with the eligible insurer
22 prior to State actions.

23 “(v) Consistency of reporting require-
24 ments with the recordkeeping and adminis-
25 trative practices of the eligible insurer.

1 “(vi) Examinations that seek to cor-
2 rect material errors and harmful business
3 practices rather than infrequent errors.

4 “(vii) Transparency and publishing of
5 the State’s examination standards.

6 “(viii) Coordination of market conduct
7 analysis.

8 “(ix) Coordination and nonduplication
9 between State examinations of the same el-
10 igible insurer.

11 “(x) Rationale and protocols to be
12 met before a full examination is conducted.

13 “(xi) Requirements on examiners
14 prior to beginning examinations such as
15 budget planning and work plans.

16 “(xii) Consideration of methods to
17 limit examiners’ fees such as caps, com-
18 petitive bidding, or other alternatives.

19 “(xiii) Reasonable fines and penalties
20 for material errors and harmful business
21 practices.

22 “(C) PROMPT PAYMENT OF CLAIMS.—The
23 Board shall establish prompt payment stand-
24 ards for eligible insurers based on standards
25 similar to those applicable to the Social Secu-

1 rity Act as set forth in section 1842(c)(2) of
2 such Act (42 U.S.C. 1395u(c)(2)). Such prompt
3 payment standards shall be consistent with the
4 timing and notice requirements of the claims
5 procedure rules to be specified under subpara-
6 graph (D), and shall include appropriate excep-
7 tions such as for fraud, nonpayment of pre-
8 miums, or late submission of claims.

9 “(D) INTERNAL REVIEW.—The Board
10 shall establish standards for claims procedures
11 for eligible insurers that are consistent with the
12 requirements relating to initial claims for bene-
13 fits and appeals of claims for benefits under the
14 Employee Retirement Income Security Act of
15 1974 as set forth in section 503 of such Act
16 (29 U.S.C. 1133) and the regulations there-
17 under.

18 “(2) RECOMMENDATIONS.—The Board shall
19 recommend harmonized standards for each element
20 of the categories described in subparagraph (A)
21 through (D) of paragraph (1) within each such mar-
22 ket. Notwithstanding the previous sentence, the
23 Board shall not recommend any harmonized stand-
24 ards that disrupt, expand, or duplicate the benefit,
25 service, or provider mandate standards provided in

1 the Benefit Choice Standards pursuant to section
2 2922(a).

3 “(c) PROCESS FOR IDENTIFYING HARMONIZED
4 STANDARDS.—

5 “(1) IN GENERAL.—The Board shall develop
6 recommendations to harmonize inconsistent State in-
7 surance laws with respect to each of the process cat-
8 egories described in subparagraphs (A) through (D)
9 of subsection (b)(1).

10 “(2) REQUIREMENTS.—In adopting standards
11 under this section, the Board shall consider the fol-
12 lowing:

13 “(A) Any model acts or regulations of the
14 National Association of Insurance Commis-
15 sioners in each of the process categories de-
16 scribed in subparagraphs (A) through (D) of
17 subsection (b)(1).

18 “(B) Substantially similar standards fol-
19 lowed by a plurality of States, as reflected in
20 existing State laws, relating to the specific proc-
21 ess categories described in subparagraphs (A)
22 through (D) of subsection (b)(1).

23 “(C) Any Federal law requirement related
24 to specific process categories described in sub-

1 paragraphs (A) through (D) of subsection
2 (b)(1).

3 “(D) In the case of the adoption of any
4 standard that differs substantially from those
5 referred to in subparagraphs (A), (B), or (C),
6 the Board shall provide evidence to the Sec-
7 retary that such standard is necessary to pro-
8 tect health insurance consumers or promote
9 speed to market or administrative efficiency.

10 “(E) The criteria specified in clauses (i)
11 through (iii) of subsection (d)(2)(B).

12 “(d) RECOMMENDATIONS AND CERTIFICATION BY
13 SECRETARY.—

14 “(1) RECOMMENDATIONS.—Not later than 18
15 months after the date on which all members of the
16 Board are selected under subsection (a), the Board
17 shall recommend to the Secretary the certification of
18 the harmonized standards identified pursuant to
19 subsection (c).

20 “(2) CERTIFICATION.—

21 “(A) IN GENERAL.—Not later than 120
22 days after receipt of the Board’s recommenda-
23 tions under paragraph (1), the Secretary shall
24 certify the recommended harmonized standards
25 as provided for in subparagraph (B), and issue

1 such standards in the form of an interim final
2 regulation.

3 “(B) CERTIFICATION PROCESS.—The Sec-
4 retary shall establish a process for certifying
5 the recommended harmonized standard, by cat-
6 egory, as recommended by the Board under this
7 section. Such process shall—

8 “(i) ensure that the certified stand-
9 ards for a particular process area achieve
10 regulatory harmonization with respect to
11 health plans on a national basis;

12 “(ii) ensure that the approved stand-
13 ards are the minimum necessary, with re-
14 gard to substance and quantity of require-
15 ments, to protect health insurance con-
16 sumers and maintain a competitive regu-
17 latory environment; and

18 “(iii) ensure that the approved stand-
19 ards will not limit the range of group
20 health plan designs and insurance prod-
21 ucts, such as catastrophic coverage only
22 plans, health savings accounts, and health
23 maintenance organizations, that might oth-
24 erwise be available to consumers.

1 “(3) APPLICATION AND EFFECTIVE DATE.—

2 The standards certified by the Secretary under para-
3 graph (2) shall apply and become effective on the
4 date that is 18 months after the date on which the
5 Secretary certifies the harmonized standards.

6 “(e) TERMINATION.—The Board shall terminate and
7 be dissolved after making the recommendations to the Sec-
8 retary pursuant to subsection (d)(1).

9 “(f) ONGOING REVIEW.—Not earlier than 3 years
10 after the termination of the Board under subsection (e),
11 and not earlier than every 3 years thereafter, the Sec-
12 retary, in consultation with the National Association of In-
13 surance Commissioners and the entities and constituencies
14 represented on the Board and the Advisory Panel, shall
15 prepare and submit to the appropriate committees of Con-
16 gress a report that assesses the effect of the harmonized
17 standards applied under this section on access, cost, and
18 health insurance market functioning. The Secretary may,
19 based on such report and applying the process established
20 for certification under subsection (d)(2)(B), in consulta-
21 tion with the National Association of Insurance Commis-
22 sioners and the entities and constituencies represented on
23 the Board and the Advisory Panel, update the harmonized
24 standards through notice and comment rulemaking.

25 “(g) PUBLICATION.—

1 “(1) LISTING.—The Secretary shall maintain
 2 an up to date listing of all harmonized standards
 3 certified under this section on the Internet website
 4 of the Department of Health and Human Services.

5 “(2) SAMPLE CONTRACT LANGUAGE.—The Sec-
 6 retary shall publish on the Internet website of the
 7 Department of Health and Human Services sample
 8 contract language that incorporates the harmonized
 9 standards certified under this section, which may be
 10 used by insurers seeking to qualify as an eligible in-
 11 surer. The types of harmonized standards that shall
 12 be included in sample contract language are the
 13 standards that are relevant to the contractual bar-
 14 gain between the insurer and insured.

15 “(h) STATE ADOPTION AND ENFORCEMENT.—Not
 16 later than 18 months after the certification by the Sec-
 17 retary of harmonized standards under this section, the
 18 States may adopt such harmonized standards (and become
 19 an adopting State) and, in which case, shall enforce the
 20 harmonized standards pursuant to State law.

21 **“SEC. 2933. APPLICATION AND PREEMPTION.**

22 “(a) SUPERCEDING OF STATE LAW.—

23 “(1) IN GENERAL.—The harmonized standards
 24 certified under this subtitle and applied as provided
 25 for in section 2933(d)(3), shall supersede any and

all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

“(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a non-adopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

“(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

“(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

“(b) SAVINGS CLAUSE AND CONSTRUCTION.—

“(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

1 “(2) NONAPPLICATION TO CERTAIN INSUR-
2 ERS.—Subsection (a) shall not apply with respect to
3 insurers that do not qualify as eligible insurers who
4 offer health insurance coverage in a nonadopting
5 State.

6 “(3) NONAPPLICATION WHERE OBTAINING RE-
7 LIEF UNDER STATE LAW.—Subsection (a)(1) shall
8 not supercede any State law of a nonadopting State
9 to the extent necessary to permit individuals or the
10 insurance department of the State (or other State
11 agency) to obtain relief under State law to require
12 an eligible insurer to comply with the harmonized
13 standards under this subtitle.

14 “(4) NO EFFECT ON PREEMPTION.—In no case
15 shall this subtitle be construed to limit or affect in
16 any manner the preemptive scope of sections 502
17 and 514 of the Employee Retirement Income Secu-
18 rity Act of 1974. In no case shall this subtitle be
19 construed to create any cause of action under Fed-
20 eral or State law or enlarge or affect any remedy
21 available under the Employee Retirement Income
22 Security Act of 1974.

23 “(c) EFFECTIVE DATE.—This section shall apply be-
24 ginning on the date that is 18 months after the date on

1 harmonized standards are certified by the Secretary under
2 this subtitle.

3 **“SEC. 2934. CIVIL ACTIONS AND JURISDICTION.**

4 “(a) IN GENERAL.—The district courts of the United
5 States shall have exclusive jurisdiction over civil actions
6 involving the interpretation of this subtitle.

7 “(b) ACTIONS.—An eligible insurer may bring an ac-
8 tion in the district courts of the United States for injunc-
9 tive or other equitable relief against any officials or agents
10 of a nonadopting State in connection with any conduct or
11 action, or proposed conduct or action, by such officials or
12 agents which violates, or which would if undertaken vio-
13 late, section 2933.

14 “(c) DIRECT FILING IN COURT OF APPEALS.—At the
15 election of the eligible insurer, an action may be brought
16 under subsection (b) directly in the United States Court
17 of Appeals for the circuit in which the nonadopting State
18 is located by the filing of a petition for review in such
19 Court.

20 “(d) EXPEDITED REVIEW.—

21 “(1) DISTRICT COURT.—In the case of an ac-
22 tion brought in a district court of the United States
23 under subsection (b), such court shall complete such
24 action, including the issuance of a judgment, prior
25 to the end of the 120-day period beginning on the

1 date on which such action is filed, unless all parties
2 to such proceeding agree to an extension of such pe-
3 riod.

4 “(2) COURT OF APPEALS.—In the case of an
5 action brought directly in a United States Court of
6 Appeal under subsection (c), or in the case of an ap-
7 peal of an action brought in a district court under
8 subsection (b), such Court shall complete all action
9 on the petition, including the issuance of a judg-
10 ment, prior to the end of the 60-day period begin-
11 ning on the date on which such petition is filed with
12 the Court, unless all parties to such proceeding
13 agree to an extension of such period.

14 “(e) STANDARD OF REVIEW.—A court in an action
15 filed under this section, shall render a judgment based on
16 a review of the merits of all questions presented in such
17 action and shall not defer to any conduct or action, or
18 proposed conduct or action, of a nonadopting State.

19 **“SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE**
20 **OF CONSTRUCTION.**

21 “(a) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated such sums as may be
23 necessary to carry out this subtitle.

24 “(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this
25 subtitle shall be construed to create any mandates for cov-

1 erage of any benefits below the deductible levels set for
 2 any health savings account-qualified health plan pursuant
 3 to section 223 of the Internal Revenue Code of 1986.”.

4 **TITLE III—AFFORDABLE ACCESS**
 5 **TO HEALTH CARE FOR ALL**
 6 **AMERICANS**

7 **Subtitle A—Improving the Quality**
 8 **of Health Care by More Effec-**
 9 **tively Using Health Information**
 10 **Technology**

11 **SEC. 300. SHORT TITLE.**

12 This subtitle may be cited as the “Wired for Health
 13 Care Quality Act”.

14 **PART I—HEALTH INFORMATION TECHNOLOGY**

15 **Subpart A—Improving the Interoperability of Health**
 16 **Information Technology**

17 **SEC. 301. IMPROVING HEALTH CARE QUALITY, SAFETY,**
 18 **AND EFFICIENCY.**

19 The Public Health Service Act (42 U.S.C. 201 et
 20 seq.) is amended by adding at the end the following:

21 **“TITLE XXX—HEALTH INFORMA-**
 22 **TION TECHNOLOGY AND**
 23 **QUALITY**

24 **“SEC. 3001. DEFINITIONS; REFERENCE.**

25 **“(a) IN GENERAL.—In this title:**

1 “(1) COMMUNITY.—The term ‘Community’
2 means the American Health Information Community
3 established under section 3004.

4 “(2) HEALTH CARE PROVIDER.—The term
5 ‘health care provider’ means a hospital, skilled nurs-
6 ing facility, home health entity, health care clinic,
7 federally qualified health center, group practice (as
8 defined in section 1877(h)(4) of the Social Security
9 Act), a pharmacist, a pharmacy, a laboratory, a phy-
10 sician (as defined in section 1861(r) of the Social
11 Security Act), a practitioner (as defined in section
12 1842(b)(18)(CC) of the Social Security Act), a
13 health facility operated by or pursuant to a contract
14 with the Indian Health Service, a rural health clinic,
15 and any other category of facility or clinician deter-
16 mined appropriate by the Secretary.

17 “(3) HEALTH INFORMATION.—The term ‘health
18 information’ has the meaning given such term in
19 section 1171(4) of the Social Security Act.

20 “(4) HEALTH INSURANCE PLAN.—

21 “(A) IN GENERAL.—The term ‘health in-
22 surance plan’ means—

23 “(i) a health insurance issuer (as de-
24 fined in section 2791(b)(2));

1 “(ii) a group health plan (as defined
2 in section 2791(a)(1)); and

3 “(iii) a health maintenance organiza-
4 tion (as defined in section 2791(b)(3)); or

5 “(iv) a safety net health plan.

6 “(B) SAFETY NET HEALTH PLAN.—The
7 term ‘safety net health plan’ means a managed
8 care organization, as defined in section
9 1932(a)(1)(B)(i) of the Social Security Act—

10 “(i) that is exempt from or not sub-
11 ject to Federal income tax, or that is
12 owned by an entity or entities exempt from
13 or not subject to Federal income tax; and

14 “(ii) for which not less than 75 per-
15 cent of the enrolled population receives
16 benefits under a Federal health care pro-
17 gram (as defined in section 1128B(f)(1) of
18 the Social Security Act) or a health care
19 plan or program which is funded, in whole
20 or in part, by a State (other than a pro-
21 gram for government employees).

22 “(C) REFERENCES.—All references in this
23 title to ‘health plan’ shall be deemed to be ref-
24 erences to ‘health insurance plan’.

1 “(5) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
2 FORMATION.—The term ‘individually identifiable
3 health information’ has the meaning given such term
4 in section 1171 of the Social Security Act.

5 “(6) LABORATORY.—The term ‘laboratory’ has
6 the meaning given such term in section 353.

7 “(7) NATIONAL COORDINATOR.—The term ‘Na-
8 tional Coordinator’ means the National Coordinator
9 of Health Information Technology appointed pursu-
10 ant to section 3002.

11 “(8) PARTNERSHIP.—The term ‘Partnership’
12 means the Partnership for Health Care Improve-
13 ment established under section 3003.

14 “(9) QUALIFIED HEALTH INFORMATION TECH-
15 NOLOGY.—The term ‘qualified health information
16 technology’ means a computerized system (including
17 hardware and software) that—

18 “(A) protects the privacy and security of
19 health information;

20 “(B) maintains and provides permitted ac-
21 cess to health information in an electronic for-
22 mat;

23 “(C) with respect to individually identifi-
24 able health information maintained in a des-
25 ignated record set, preserves an audit trail of

1 each individual that has gained access to such
2 record set;

3 “(D) incorporates decision support to re-
4 duce medical errors and enhance health care
5 quality;

6 “(E) complies with the standards adopted
7 by the Federal Government under section 3003;

8 “(F) has the ability to transmit and ex-
9 change information to other health information
10 technology systems and, to the extent feasible,
11 public health information technology systems;
12 and

13 “(G) allows for the reporting of quality
14 measures adopted under section 3010.

15 “(10) STATE.—The term ‘State’ means each of
16 the several States, the District of Columbia, Puerto
17 Rico, the Virgin Islands, Guam, American Samoa,
18 and the Northern Mariana Islands.

19 “(b) REFERENCES TO SOCIAL SECURITY ACT.—Any
20 reference in this section to the Social Security Act shall
21 be deemed to be a reference to such Act as in effect on
22 the date of enactment of this title.

1 **“SEC. 3002. OFFICE OF THE NATIONAL COORDINATOR FOR**
2 **HEALTH INFORMATION TECHNOLOGY.**

3 “(a) ESTABLISHMENT.—There is established within
4 the office of the Secretary, the Office of the National Co-
5 ordinator of Health Information Technology. The Na-
6 tional Coordinator shall be appointed by the Secretary in
7 consultation with the President, and shall report directly
8 to the Secretary.

9 “(b) PURPOSE.—The Office of the National Coordi-
10 nator shall be responsible for—

11 “(1) ensuring that key health information tech-
12 nology initiatives are coordinated across programs of
13 the Department of Health and Human Services;

14 “(2) ensuring that health information tech-
15 nology policies and programs of the Department of
16 Health and Human Services are coordinated with
17 such policies and programs of other relevant Federal
18 agencies (including Federal commissions and advi-
19 sory committees) with a goal of avoiding duplication
20 of efforts and of helping to ensure that each agency
21 undertakes activities primarily within the areas of its
22 greatest expertise and technical capability;

23 “(3) reviewing Federal health information tech-
24 nology investments to ensure that Federal health in-
25 formation technology programs are meeting the ob-
26 jectives of the strategic plan published by the Office

of the National Coordinator of Health Information Technology to establish a nationwide interoperable health information technology infrastructure;

“(4) providing comments and advice regarding specific Federal health information technology programs, at the request of Office of Management and Budget; and

“(5) enhancing the use of health information technology to improve the quality of health care in the prevention and management of chronic disease and to address population health.

“(c) **ROLE WITH COMMUNITY AND THE PARTNERSHIP.**—The Office of the National Coordinator shall—

“(1) serve as an ex officio member of the Community, and act as a liaison between the Federal Government and the Community;

“(2) serve as an ex officio member of the Partnership and act as a liaison between the Federal Government and the Partnership; and

“(3) serve as a liaison between the Partnership and the Community.

“(d) **REPORTS AND WEBSITE.**—The Office of the National Coordinator shall—

1 “(1) develop and publish a strategic plan for
2 implementing a nationwide interoperable health in-
3 formation technology infrastructure;

4 “(2) maintain and frequently update an Inter-
5 net website that—

6 “(A) publishes the schedule for the assess-
7 ment of standards for significant use cases;

8 “(B) publishes the recommendations of the
9 Community;

10 “(C) publishes the recommendations of the
11 Partnership;

12 “(D) publishes quality measures;

13 “(E) identifies sources of funds that will
14 be made available to facilitate the purchase of,
15 or enhance the utilization of, health information
16 technology systems, either through grants or
17 technical assistance; and

18 “(F) publishes a plan for a transition of
19 any functions of the Office of the National Co-
20 ordinator that should be continued after Sep-
21 tember 30, 2014;

22 “(3) prepare a report on the lessons learned
23 from major public and private health care systems
24 that have implemented health information tech-
25 nology systems, including an explanation of whether

the systems and practices developed by such systems
 may be applicable to and usable in whole or in part
 by other health care providers; and

“(4) assess the impact of health information
 technology in communities with health disparities
 and identify practices to increase the adoption of
 such technology by health care providers in such
 communities.

“(e) RULE OF CONSTRUCTION.—Nothing in this sec-
 tion shall be construed as requiring the duplication of Fed-
 eral efforts with respect to the establishment of the Office
 of the National Coordinator for Health Information Tech-
 nology, regardless of whether such efforts are carried out
 before or after the date of the enactment of this title.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There
 is authorized to be appropriated to carry out this section,
 \$5,000,000 for each of fiscal years 2008 and 2009.

“(g) SUNSET.—The provisions of this section shall
 not apply after September 30, 2014.

**“SEC. 3003. PARTNERSHIP FOR HEALTH CARE IMPROVE-
 MENT-STANDARDS AND TECHNOLOGY.**

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—There is established a pub-
 lic-private Partnership for Health Care Improvement
 to—

1 “(A) provide advice to the Secretary and
2 the Nation and recommend specific actions to
3 achieve a nationwide interoperable health infor-
4 mation technology infrastructure;

5 “(B) make recommendations concerning
6 standards, implementation specifications, and
7 certification criteria for the electronic exchange
8 of health information (including for the report-
9 ing of quality data under section 3010) for
10 adoption by the Federal Government and vol-
11 untary adoption by private entities;

12 “(C) serve as a forum for the participation
13 of a broad range of stakeholders with specific
14 technical expertise in the development of stand-
15 ards, implementation specifications, and certifi-
16 cation criteria to provide input on the effective
17 implementation of health information tech-
18 nology systems; and

19 “(D) develop and maintain an Internet
20 website that—

21 “(i) publishes established governance
22 rules (including a subsequent appointment
23 process);

24 “(ii) publishes a business plan;

1 “(iii) publishes meeting notices at
2 least 14 days prior to each meeting;

3 “(iv) publishes meeting agendas at
4 least 7 days prior to each meeting; and

5 “(v) publishes meeting materials at
6 least 3 days prior to each meeting.

7 “(2) LIMITATION.—The Partnership shall not
8 meet or take any action until an advisory committee
9 charter has been filed with the Secretary and with
10 the appropriate committees of the Senate and House
11 of Representatives for the Community described in
12 section 3004.

13 “(b) MEMBERSHIP.—

14 “(1) APPOINTMENTS.—

15 “(A) IN GENERAL.—The Partnership shall
16 be composed of members to be appointed as fol-
17 lows:

18 “(i) 2 members shall be appointed by
19 the Secretary.

20 “(ii) 1 member shall be appointed by
21 the majority leader of the Senate.

22 “(iii) 1 member shall be appointed by
23 the minority leader of the Senate.

1 “(iv) 1 member shall be appointed by
2 the Speaker of the House of Representa-
3 tives.

4 “(v) 1 member shall be appointed by
5 the minority leader of the House of Rep-
6 resentatives.

7 “(vi) Seven members shall be ap-
8 pointed by the Comptroller General of
9 whom—

10 “(I) one member shall be a rep-
11 resentative of consumer or patient or-
12 ganizations;

13 “(II) one member shall be a rep-
14 resentative of organizations with ex-
15 pertise in privacy;

16 “(III) one member shall be a rep-
17 resentative of organizations with ex-
18 pertise in security;

19 “(IV) one member shall be a rep-
20 resentative of health care providers;

21 “(V) one member shall be a rep-
22 resentative of health plans or other
23 third party payers;

1 “(VI) one member shall be a rep-
2 resentative of information technology
3 vendors; and

4 “(VII) one member shall be a
5 representative of purchasers or em-
6 ployers.

7 “(B) NATIONAL COORDINATOR.—The Na-
8 tional Coordinator shall be a member of the
9 Partnership and act as a liaison among the
10 Partnership, the community, and the Federal
11 Government.

12 “(2) CHAIRPERSON AND VICE CHAIRPERSON.—
13 The Partnership shall designate one member to
14 serve as the chairperson and one member to serve as
15 the vice chairperson of the Partnership.

16 “(3) PARTICIPATION.—In appointing members
17 under paragraph (1)(A), and in developing the pro-
18 cedures for conducting the activities of the Partner-
19 ship, the Partnership shall ensure a balance among
20 various sectors of the health care system so that no
21 single sector unduly influences the recommendations
22 of the Partnership.

23 “(4) TERMS.—Members appointed under para-
24 graph (1)(A) shall serve for 3 year terms, except
25 that any member appointed to fill a vacancy for an

1 unexpired term shall be appointed for the remainder
 2 of such term. A member may serve for not to exceed
 3 180 days after the expiration of such member's term
 4 or until a successor has been appointed.

5 “(5) OUTSIDE INVOLVEMENT.—The Partner-
 6 ship shall ensure an adequate opportunity for the
 7 participation of outside advisors, including individ-
 8 uals with expertise in—

9 “(A) health information privacy;

10 “(B) health information security;

11 “(C) health care quality and patient safety,
 12 including individuals with expertise in utilizing
 13 health information technology to improve health
 14 care quality and patient safety;

15 “(D) medical and clinical research data ex-
 16 change; and

17 “(E) developing health information tech-
 18 nology standards and new health information
 19 technology.

20 “(6) QUORUM.—Two-thirds of the members of
 21 the Partnership shall constitute a quorum for the
 22 purpose of conducting votes.

23 “(c) STANDARDS AND IMPLEMENTATION SPECIFICA-
 24 TIONS.—

1 “(1) SCHEDULE.—Not later than 90 days after
2 the date of enactment of this title, the Partnership
3 shall develop a schedule for the assessment of stand-
4 ards and implementation specifications under this
5 section. The Partnership shall update such schedule
6 annually. The Secretary shall publish such schedule
7 in the Federal Register and on the Internet website
8 of the Department of Health and Human Services.

9 “(2) FIRST YEAR RECOMMENDATIONS.—Con-
10 sistent with the schedule published under paragraph
11 (1) and not later than 1 year after date of enact-
12 ment of this title, the Partnership shall recommend,
13 and the Secretary shall review, such standards and
14 implementation specifications.

15 “(3) ONGOING RECOMMENDATIONS.—The Part-
16 nership shall review and modify, as appropriate but
17 at least annually, adopted standards and implemen-
18 tation specifications and continue to recommend ad-
19 ditional standards and implementation specifications,
20 consistent with the schedule published pursuant to
21 paragraph (1). The Secretary shall review such
22 modifications and recommendations.

23 “(4) RECOGNITION OF PRIVATE ENTITIES.—
24 The Partnership, in consultation with the Secretary,
25 may recognize a private entity or entities for the

1 purpose of developing and updating standards and
2 implementation specifications to achieve uniform and
3 consistent implementation of the standards adopted
4 by the President under this title. Such entity or enti-
5 ties shall make recommendations to the Partnership
6 consistent with this section.

7 “(5) PUBLICATION.—All recommendations
8 made by the Partnership pursuant to this section
9 shall be published in the Federal Register and on
10 the Internet website of the Office of the National
11 Coordinator.

12 “(6) PILOT TESTING.—The Secretary may con-
13 duct, or recognize a private entity or entities to con-
14 duct, a pilot project to test the standards and imple-
15 mentation specifications developed under this section
16 in order to provide for the efficient implementation
17 of the standards and implementation specifications
18 described in this subsection prior to issuing such
19 recommendations.

20 “(7) PUBLIC INPUT.—The Partnership shall
21 conduct open public meetings and develop a process
22 to allow for public comment on the schedule and rec-
23 ommendations described in this section. Such proc-
24 ess shall ensure that such comments will be sub-

mitted within 30 days of the publication of a recommendation under this section.

“(8) FEDERAL ACTION.—Not later than 90 days after the issuance of a recommendation from the Partnership under this subsection, the Secretary, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies as determined appropriate by the President, shall jointly review such recommendation. If appropriate, the President shall provide for the adoption by the Federal Government of any standard or implementation specification contained in such recommendation. Such determination shall be published in the Federal Register and on the Internet website of the Office of the National Coordinator within 30 days after such determination is made.

“(9) CONSISTENCY.—The standards and implementation specifications described in this subsection shall be consistent with the standards for information transactions and data elements developed pursuant to the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(d) CERTIFICATION.—

1 “(1) DEVELOPING CRITERIA.—The Partner-
2 ship, in consultation with the Secretary, may recog-
3 nize a private entity or entities for the purpose of
4 developing and recommending to the Partnership
5 criteria to certify that appropriate categories of
6 health information technology products that claim to
7 be in compliance with applicable standards and im-
8 plementation specifications adopted under this title
9 have established such compliance.

10 “(2) ADOPTION OF CRITERIA.—The Secretary,
11 based upon the recommendations of the Partnership,
12 shall review, and if appropriate, adopt such criteria.

13 “(3) CONDUCTING CERTIFICATION.—The Sec-
14 retary may recognize a private entity or entities to
15 conduct the certifications described under paragraph
16 (1) using the criteria adopted by the Secretary
17 under this subsection.

18 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
19 tion shall be construed as disrupting existing activities de-
20 scribed in subsection (c) or (d).

21 “(f) REQUIREMENT TO CONSIDER RECOMMENDA-
22 TIONS.—In carrying out the activities described in sub-
23 sections (c) and (d), the Partnership shall adopt and inte-
24 grate the recommendations of the Community that are
25 adopted by the Secretary.

1 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated to carry out this section,
 3 \$2,000,000 for each of the fiscal years 2008 and 2009.

4 **“SEC. 3004. AMERICAN HEALTH INFORMATION COMMU-**
 5 **NITY—POLICIES.**

6 “(a) ESTABLISHMENT.—There is established a com-
 7 mittee to be known as the American Health Information
 8 Community. The Community shall—

9 “(1) provide advice to the Secretary and the
 10 heads of any relevant Federal agencies concerning
 11 the policy considerations related to health informa-
 12 tion technology;

13 “(2) not later than 1 year after the date of en-
 14 actment of this title, and annually thereafter, make
 15 recommendations concerning a policy framework for
 16 the development and adoption of a nationwide inter-
 17 operable health information technology infrastruc-
 18 ture;

19 “(3) not later than 1 year after the date of en-
 20 actment of this title, and annually thereafter, make
 21 recommendation concerning national policies for
 22 adoption by the Federal Government, and voluntary
 23 adoption by private entities, to support the wide-
 24 spread adoption of health information technology,
 25 including—

1 “(A) the protection of individually identifi-
2 able health information, including policies con-
3 cerning the individual’s ability to control the ac-
4 quisition, uses, and disclosures of individually
5 identifiable health information;

6 “(B) methods to protect individually iden-
7 tifiable health information from improper use
8 and disclosures and methods to notify patients
9 if their individually identifiable health informa-
10 tion is wrongfully disclosed;

11 “(C) methods to facilitate secure access to
12 such individual’s individually identifiable health
13 information;

14 “(D) the appropriate uses of a nationwide
15 health information network including—

16 “(i) the collection of quality data and
17 public reporting;

18 “(ii) biosurveillance and public health;

19 “(iii) medical and clinical research;

20 and

21 “(iv) drug safety;

22 “(E) fostering the public understanding of
23 health information technology;

1 “(F) strategies to enhance the use of
2 health information technology in preventing and
3 managing chronic disease;

4 “(G) policies to incorporate the input of
5 employees of health care providers in the design
6 and implementation of health information tech-
7 nology systems; and

8 “(H) other policies determined to be nec-
9 essary by the Community; and

10 “(4) serve as a forum for the participation of
11 a broad range of stakeholders to provide input on
12 improving the effective implementation of health in-
13 formation technology systems.

14 “(b) PUBLICATION.—All recommendations made by
15 the Community pursuant to this section shall be published
16 in the Federal Register and on the Internet website of the
17 National Coordinator. The Secretary shall review all rec-
18 ommendations and determine which recommendations
19 shall be endorsed by the Federal Government and such
20 determination shall be published on the Internet website
21 of the Office of the National Coordinator within 30 days
22 after the date on which such endorsement is made.

23 “(c) MEMBERSHIP.—

24 “(1) IN GENERAL.—The Community shall be
25 composed of members to be appointed as follows:

1 “(A) 3 members shall be appointed by the
2 Secretary, 1 of whom shall be a representative
3 from the Department of Health and Human
4 Services.

5 “(B) 1 member shall be appointed by the
6 Secretary of Veterans Affairs who shall rep-
7 resent the Department of Veterans Affairs.

8 “(C) 1 member shall be appointed by the
9 Secretary of Defense who shall represent the
10 Department of Defense.

11 “(D) 1 member shall be appointed by the
12 majority leader of the Senate.

13 “(E) 1 member shall be appointed by the
14 minority leader of the Senate.

15 “(F) 1 member shall be appointed by the
16 Speaker of the House of Representatives.

17 “(G) 1 member shall be appointed by the
18 minority leader of the House of Representa-
19 tives.

20 “(H) Nine members shall be appointed by
21 the Comptroller General of whom—

22 “(i) one member shall be advocates
23 for patients or consumers;

24 “(ii) one member shall represent
25 health care providers;

1 “(iii) one member shall be from a
2 labor organization representing health care
3 workers;

4 “(iv) one member shall have expertise
5 in privacy and security;

6 “(v) one member shall have expertise
7 in improving the health of vulnerable popu-
8 lations;

9 “(vi) one member shall represent
10 health plans or other third party payers;

11 “(vii) one member shall represent in-
12 formation technology vendors;

13 “(viii) one member shall represent
14 purchasers or employers; and

15 “(ix) one member shall have expertise
16 in health care quality measurement and re-
17 porting.

18 “(2) CHAIRPERSON AND VICE CHAIRPERSON.—
19 The Community shall designate one member to serve
20 as the chairperson and one member to serve as the
21 vice chairperson of the Community.

22 “(3) NATIONAL COORDINATOR.—The National
23 Coordinator shall be a member of the Community
24 and act as a liaison among the Community, the
25 partnership, and the Federal Government.

1 “(4) PARTICIPATION.—The members of the
2 Community appointed under paragraph (1) shall
3 represent a balance among various sectors of the
4 health care system so that no single sector unduly
5 influences the recommendations of the Community.

6 “(5) TERMS.—

7 “(A) IN GENERAL.—The terms of mem-
8 bers of the Community shall be for 3 years ex-
9 cept that the Comptroller General shall des-
10 ignate staggered terms for the members first
11 appointed.

12 “(B) VACANCIES.—Any member appointed
13 to fill a vacancy in the membership of the Com-
14 munity that occurs prior to the expiration of
15 the term for which the member’s predecessor
16 was appointed shall be appointed only for the
17 remainder of that term. A member may serve
18 after the expiration of that member’s term until
19 a successor has been appointed. A vacancy in
20 the Community shall be filled in the manner in
21 which the original appointment was made.

22 “(6) OUTSIDE INVOLVEMENT.—The Commu-
23 nity shall ensure an adequate opportunity for the
24 participation of outside advisors, including individ-
25 uals with expertise in—

1 “(A) health information privacy and secu-
2 rity;

3 “(B) improving the health of vulnerable
4 populations;

5 “(C) health care quality and patient safety,
6 including individuals with expertise in measure-
7 ment and the use of health information tech-
8 nology to capture data to improve health care
9 quality and patient safety;

10 “(D) ethics;

11 “(E) medical and clinical research data ex-
12 change; and

13 “(F) developing health information tech-
14 nology standards and new health information
15 technology.

16 “(7) QUORUM.—Ten members of the Commu-
17 nity shall constitute a quorum for purposes of vot-
18 ing, but a lesser number of members may meet and
19 hold hearings.

20 “(d) FEDERAL AGENCIES.—

21 “(1) STAFF OF OTHER FEDERAL AGENCIES.—
22 Upon the request of the Community, the head of any
23 Federal agency may detail, without reimbursement,
24 any of the personnel of such agency to the Commu-
25 nity to assist in carrying out the duties of the Com-

1 munity. Any such detail shall not interrupt or other-
2 wise affect the civil service status or privileges of the
3 Federal employee involved.

4 “(2) TECHNICAL ASSISTANCE.—Upon the re-
5 quest of the Community, the head of a Federal
6 agency shall provide such technical assistance to the
7 Community as the Community determines to be nec-
8 essary to carry out its duties.

9 “(3) OTHER RESOURCES.—The Community
10 shall have reasonable access to materials, resources,
11 statistical data, and other information from the Li-
12 brary of Congress and agencies and elected rep-
13 resentatives of the executive and legislative branches
14 of the Federal Government. The chairperson or vice
15 chairperson of the Community shall make requests
16 for such access in writing when necessary.

17 “(e) APPLICATION OF FACA.—The Federal Advisory
18 Committee Act (5 U.S.C. App.) shall apply to the Commu-
19 nity, except that the term provided for under section
20 14(a)(2) of such Act shall be not longer than 7 years.

21 “(f) SUNSET.—The provisions of this section shall
22 not apply after September 20, 2014.

23 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section,
25 \$2,000,000 for each of fiscal years 2008 and 2009.

1 **“SEC. 3005. FEDERAL PURCHASING AND DATA COLLEC-**
2 **TION.**

3 “(a) COORDINATION OF FEDERAL SPENDING.—

4 “(1) IN GENERAL.—Not later than 1 year after
5 the adoption by the President of a recommendation
6 under section 3003(c)(6), a Federal agency shall not
7 expend Federal funds for the purchase of any new
8 health information technology or health information
9 technology system for clinical care or for the elec-
10 tronic retrieval, storage, or exchange of health infor-
11 mation if such technology or system is not consistent
12 with applicable standards adopted by the Federal
13 Government under section 3003.

14 “(2) RULE OF CONSTRUCTION.—Nothing in
15 paragraph (1) shall be construed to restrict the pur-
16 chase of minor (as determined by the Secretary)
17 hardware or software components in order to mod-
18 ify, correct a deficiency in, or extend the life of exist-
19 ing hardware or software.

20 “(b) VOLUNTARY ADOPTION.—

21 “(1) IN GENERAL.—Any standards and imple-
22 mentation specifications adopted by the Federal
23 Government under section 303(c)(6) shall be vol-
24 untary with respect to private entities.

25 “(2) REQUIREMENT.—Private entities that
26 enter into a contract with the Federal Government

1 shall adopt the standards and implementation speci-
2 fications adopted by the Federal Government under
3 this section for the purpose of activities under such
4 Federal contract.

5 “(3) RULE OF CONSTRUCTION.—Nothing in
6 this section shall be construed to require that a pri-
7 vate entity that enters into a contract with the Fed-
8 eral Government adopt the standards and implemen-
9 tation specifications adopted by the Federal Govern-
10 ment under this section with respect to activities not
11 related to the contract.

12 “(c) COORDINATION OF FEDERAL DATA COLLEC-
13 TION.—Not later than 3 years after the adoption by the
14 Federal Government of a recommendation as provided for
15 in section 303(c)(6), all Federal agencies collecting health
16 data in an electronic format for the purposes of quality
17 reporting, surveillance, epidemiology, adverse event report-
18 ing, research, or for other purposes determined appro-
19 priate by the Secretary, shall comply with the standards
20 and implementation specifications adopted under such
21 subsection.

22 **“SEC. 3006. QUALITY AND EFFICIENCY REPORTS.**

23 “(a) PURPOSE.—The purpose of this section is to
24 provide for the development of reports based on Federal
25 health care data and private data that is publicly available

1 or is provided by the entity making the request for the
2 report in order to—

3 “(1) improve the quality and efficiency of
4 health care and advance health care research;

5 “(2) enhance the education and awareness of
6 consumers for evaluating health care services; and

7 “(3) provide the public with reports on national,
8 regional, and provider- and supplier-specific per-
9 formance, which may be in a provider- or supplier-
10 identifiable format.

11 “(b) PROCEDURES FOR THE DEVELOPMENT OF RE-
12 PORTS.—

13 “(1) IN GENERAL.—Notwithstanding section
14 552(b)(6) or 552a(b) of title 5, United States Code,
15 not later than 12 months after the date of enact-
16 ment of this section, the Secretary, in accordance
17 with the purpose described in subsection (a), shall
18 establish and implement procedures under which an
19 entity may submit a request to a Quality Reporting
20 Organization for the Organization to develop a re-
21 port based on—

22 “(A) Federal health care data disclosed to
23 the Organization under subsection (c); and

1 “(B) private data that is publicly available
2 or is provided to the Organization by the entity
3 making the request for the report.

4 “(2) DEFINITIONS.—In this section:

5 “(A) FEDERAL HEALTH CARE DATA.—The
6 term ‘Federal health care data’ means —

7 “(i) deidentified patient enrollment
8 data, reimbursement claims, and survey
9 data maintained by the Secretary or enti-
10 ties under programs, contracts, grants, or
11 memoranda of understanding administered
12 by the Secretary; and

13 “(ii) where feasible, other deidentified
14 patient enrollment data, reimbursement
15 claims, and survey data maintained by the
16 Federal Government or entities under con-
17 tract with the Federal Government.

18 “(B) QUALITY REPORTING ORGANIZA-
19 TION.—The term ‘Quality Reporting Organiza-
20 tion’ means an entity with a contract under
21 subsection (d).

22 “(c) ACCESS TO FEDERAL HEALTH CARE DATA.—

23 “(1) IN GENERAL.—The procedures established
24 under subsection (b)(1) shall provide for the secure

1 disclosure of Federal health care data to each Qual-
2 ity Reporting Organization.

3 “(2) UPDATE OF INFORMATION.—Not less than
4 every 6 months, the Secretary shall update the infor-
5 mation disclosed under paragraph (1) to Quality Re-
6 porting Organizations.

7 “(d) QUALITY REPORTING ORGANIZATIONS.—

8 “(1) IN GENERAL.—

9 “(A) THREE CONTRACTS.—Subject to sub-
10 paragraph (B), the Secretary shall enter into a
11 contract with 3 private entities to serve as
12 Quality Reporting Organizations under which
13 an entity shall—

14 “(i) store the Federal health care data
15 that is to be disclosed under subsection (c);
16 and

17 “(ii) develop and release reports pur-
18 suant to subsection (e).

19 “(B) ADDITIONAL CONTRACTS.—If the
20 Secretary determines that reports are not being
21 developed and released within 6 months of the
22 receipt of the request for the report, the Sec-
23 retary shall enter into contracts with additional
24 private entities in order to ensure that such re-

1 ports are developed and released in a timely
2 manner.

3 “(2) QUALIFICATIONS.—The Secretary shall
4 enter into a contract with an entity under paragraph
5 (1) only if the Secretary determines that the enti-
6 ty—

7 “(A) has the research capability to conduct
8 and complete reports under this section;

9 “(B) has in place—

10 “(i) an information technology infra-
11 structure to support the database of Fed-
12 eral health care data that is to be disclosed
13 to the entity; and

14 “(ii) operational standards to provide
15 security for such database;

16 “(C) has experience with, and expertise on,
17 the development of reports on health care qual-
18 ity and efficiency; and

19 “(D) has a significant business presence in
20 the United States.

21 “(3) CONTRACT REQUIREMENTS.—Each con-
22 tract with an entity under paragraph (1) shall con-
23 tain the following requirements:

24 “(A) ENSURING BENEFICIARY PRIVACY.—

1 “(i) HIPAA.—The entity shall meet
2 the requirements imposed on a covered en-
3 tity for purposes of applying part C of title
4 XI and all regulatory provisions promul-
5 gated thereunder, including regulations
6 (relating to privacy) adopted pursuant to
7 the authority of the Secretary under sec-
8 tion 264(c) of the Health Insurance Port-
9 ability and Accountability Act of 1996 (42
10 U.S.C. 1320d–2 note).

11 “(ii) PRIVACY.—The entity shall pro-
12 vide assurances that the entity will not use
13 the Federal health care data disclosed
14 under subsection (c) in a manner that vio-
15 lates sections 552 or 552a of title 5,
16 United States Code, with regard to the pri-
17 vacy of and individual’s individually identi-
18 fiable health information.

19 “(B) PROPRIETARY INFORMATION.—The
20 entity shall provide assurances that the entity
21 will not disclose any negotiated price conces-
22 sions, such as discounts, direct or indirect sub-
23 sidies, rebates, and direct or indirect remunera-
24 tions, obtained by health care providers or sup-

1 pliers or health care plans, or any other propri-
2 etary cost information.

3 “(C) DISCLOSURE.—The entity shall dis-
4 close—

5 “(i) any financial, reporting, or con-
6 tractual relationship between the entity
7 and any health care provider or supplier or
8 health care plan; and

9 “(ii) if applicable, the fact that the
10 entity is managed, controlled, or operated
11 by any health care provider or supplier or
12 health care plan.

13 “(D) COMPONENT OF ANOTHER ORGANIZA-
14 TION.—If the entity is a component of another
15 organization—

16 “(i) the entity shall maintain Federal
17 health care data and reports separately
18 from the rest of the organization and es-
19 tablish appropriate security measures to
20 maintain the confidentiality and privacy of
21 the Federal health care data and reports;
22 and

23 “(ii) the entity shall not make an un-
24 authorized disclosure to the rest of the or-
25 ganization of Federal health care data or

reports in breach of such confidentiality and privacy requirement.

“(E) TERMINATION OR NONRENEWAL.—If a contract under this section is terminated or not renewed, the following requirements shall apply:

“(i) CONFIDENTIALITY AND PRIVACY PROTECTIONS.—The entity shall continue to comply with the confidentiality and privacy requirements under this section with respect to all Federal health care data disclosed to the entity and each report developed by the entity.

“(ii) DISPOSITION OF DATA AND REPORTS.—The entity shall—

“(I) return to the Secretary all Federal health care data disclosed to the entity and each report developed by the entity; or

“(II) if returning the Federal health care data and reports is not practicable, destroy the reports and Federal health care data.

“(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Federal

1 Procurement Policy Act) shall be used to enter into
2 contracts under paragraph (1).

3 “(5) REVIEW OF CONTRACT IN THE EVENT OF
4 A MERGER OR ACQUISITION.—The Secretary shall
5 review the contract with a Quality Reporting Orga-
6 nization under this section in the event of a merger
7 or acquisition of the Organization in order to ensure
8 that the requirements under this section will con-
9 tinue to be met.

10 “(e) DEVELOPMENT AND RELEASE OF REPORTS
11 BASED ON REQUESTS.—

12 “(1) REQUEST FOR A REPORT.—

13 “(A) REQUEST.—

14 “(i) IN GENERAL.—The procedures
15 established under subsection (b)(1) shall
16 include a process for an entity to submit a
17 request to a Quality Reporting Organiza-
18 tion for a report based on Federal health
19 care data and private data that is publicly
20 available or is provided by the entity mak-
21 ing the request for the report. Such re-
22 quest shall comply with the purpose de-
23 scribed in subsection (a).

24 “(ii) REQUEST FOR SPECIFIC METH-
25 ODOLOGY.—The process described in

1 clause (i) shall permit an entity making a
2 request for a report to request that a spe-
3 cific methodology, including appropriate
4 risk adjustment, be used by the Quality
5 Reporting Organization in developing the
6 report. The Organization shall work with
7 the entity making the request to finalize
8 the methodology to be used.

9 “(iii) REQUEST FOR A SPECIFIC
10 QRO.—The process described in clause (i)
11 shall permit an entity to submit the re-
12 quest for a report to any Quality Report-
13 ing Organization.

14 “(B) RELEASE TO PUBLIC.—The proce-
15 dures established under subsection (b)(1) shall
16 provide that at the time a request for a report
17 is finalized under subparagraph (A) by a Qual-
18 ity Reporting Organization, the Organization
19 shall make available to the public, through the
20 Internet website of the Department of Health
21 and Human Services and other appropriate
22 means, a brief description of both the requested
23 report and the methodology to be used to de-
24 velop such report.

1 “(2) DEVELOPMENT AND RELEASE OF RE-
2 PORT.—

3 “(A) DEVELOPMENT.—

4 “(i) IN GENERAL.—If the request for
5 a report complies with the purpose de-
6 scribed in subsection (a), the Quality Re-
7 porting Organization may develop the re-
8 port based on the request.

9 “(ii) REQUIREMENT.—A report devel-
10 oped under clause (i) shall include a de-
11 tailed description of the standards, meth-
12 odologies, and measures of quality used in
13 developing the report.

14 “(B) REVIEW OF REPORT BY SECRETARY
15 TO ENSURE COMPLIANCE WITH PRIVACY RE-
16 QUIREMENT.—Prior to a Quality Reporting Or-
17 ganization releasing a report under subpara-
18 graph (C), the Secretary shall review the report
19 to ensure that the report complies with the
20 Federal regulations (concerning the privacy of
21 individually identifiable beneficiary health infor-
22 mation) promulgated under section 264(c) of
23 the Health Insurance Portability and Account-
24 ability Act of 1996 and sections 552 or 552a of
25 title 5, United States Code, with regard to the

1 privacy of individually identifiable beneficiary
2 health information. The Secretary shall act
3 within 30 business days of receiving such re-
4 port.

5 “(C) RELEASE OF REPORT.—

6 “(i) RELEASE TO ENTITY MAKING RE-
7 QUEST.—If the Secretary finds that the re-
8 port complies with the provisions described
9 in subparagraph (B), the Quality Report-
10 ing Organization shall release the report to
11 the entity that made the request for the re-
12 port.

13 “(ii) RELEASE TO PUBLIC.—The pro-
14 cedures established under subsection (b)(1)
15 shall provide for the following:

16 “(I) UPDATED DESCRIPTION.—

17 At the time of the release of a report
18 by a Quality Reporting Organization
19 under clause (i), the entity shall make
20 available to the public, through the
21 Internet website of the Department of
22 Health and Human Services and
23 other appropriate means, an updated
24 brief description of both the requested

1 report and the methodology used to
2 develop such report.

3 “(II) COMPLETE REPORT.—Not
4 later than 1 year after the date of the
5 release of a report under clause (i),
6 the report shall be made available to
7 the public through the Internet
8 website of the Department of Health
9 and Human Services and other appro-
10 priate means.

11 “(f) ANNUAL REVIEW OF REPORTS AND TERMI-
12 NATION OF CONTRACTS.—

13 “(1) ANNUAL REVIEW OF REPORTS.—The
14 Comptroller General of the United States shall re-
15 view reports released under subsection (e)(2)(C) to
16 ensure that such reports comply with the purpose
17 described in subsection (a) and annually submit a
18 report to the Secretary on such review.

19 “(2) TERMINATION OF CONTRACTS.—The Sec-
20 retary may terminate a contract with a Quality Re-
21 porting Organization if the Secretary determines
22 that there is a pattern of reports being released by
23 the Organization that do not comply with the pur-
24 pose described in subsection (a).

25 “(g) FEES.—

1 “(1) FEES FOR SECRETARY.—The Secretary
2 shall charge a Quality Reporting Organization a fee
3 for—

4 “(A) disclosing the data under subsection
5 (c); and

6 “(B) conducting the review under sub-
7 section (e)(2)(B).

8 The Secretary shall ensure that such fees are suffi-
9 cient to cover the costs of the activities described in
10 subparagraph (A) and (B).

11 “(2) FEES FOR QRO.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graphs (A) and (B), a Quality Reporting Orga-
14 nization may charge an entity making a request
15 for a report a reasonable fee for the develop-
16 ment and release of the report.

17 “(B) DISCOUNT FOR SMALL ENTITIES.—In
18 the case of an entity making a request for a re-
19 port (including a not-for-profit) that has annual
20 revenue that does not exceed \$10,000,000, the
21 Quality Reporting Organization shall reduce the
22 reasonable fee charged to such entity under
23 subparagraph (A) by an amount equal to 10
24 percent of such fee.

1 “(C) INCREASE FOR LARGE ENTITIES
2 THAT DO NOT AGREE TO RELEASE REPORTS
3 WITHIN 6 MONTHS.—In the case of an entity
4 making a request for a report that is not de-
5 scribed in subparagraph (B) and that does not
6 agree to the report being released to the public
7 under clause (ii)(II) of subsection (e)(2)(C)
8 within 6 months of the date of the release of
9 the report to the entity under clause (i) of such
10 subsection, the Quality Reporting Organization
11 shall increase the reasonable fee charged to
12 such entity under subparagraph (A) by an
13 amount equal to 10 percent of such fee.

14 “(D) RULE OF CONSTRUCTION.—Nothing
15 in this paragraph shall be construed to effect
16 the requirement that a report be released to the
17 public under clause (ii)(II) of subsection
18 (e)(2)(C)(ii)(II) by not later than 1 year after
19 the date of the release of the report to the re-
20 questing entity under clause (i) of such sub-
21 section.

22 “(h) COORDINATION.—Not later than 1 year after
23 the date of enactment of this title, the Secretary shall sub-
24 mit a report (including recommendations) to the appro-

1 priate committees of Congress concerning the coordination
 2 of existing Federal health care quality initiatives.

3 “(i) REGULATIONS.—Not later than 6 months after
 4 the date of enactment of this section, the Secretary shall
 5 prescribe regulations to carry out this section.

6 **“SEC. 3007. RESEARCH ACCESS TO HEALTH CARE DATA**
 7 **AND REPORTING ON PERFORMANCE.**

8 “The Secretary shall permit researchers that meet
 9 criteria used to evaluate the appropriateness of the release
 10 data for research purpose (as established by the Sec-
 11 retary) to—

12 “(1) have access to all Federal health care data
 13 (as defined in section 3006(b)(2)(A)); and

14 “(2) report on the performance of health care
 15 providers and suppliers, including reporting in a
 16 provider- or supplier-identifiable format.”.

17 **Subpart B—Facilitating the Widespread Adoption of**
 18 **Interoperable Health Information Technology**

19 **SEC. 305. FACILITATING THE WIDESPREAD ADOPTION OF**
 20 **INTEROPERABLE HEALTH INFORMATION**
 21 **TECHNOLOGY.**

22 Title XXX of the Public Health Service Act, as added
 23 by section 301, is amended by adding at the end the fol-
 24 lowing:

1 **“SEC. 3008. FACILITATING THE WIDESPREAD ADOPTION OF**
2 **INTEROPERABLE HEALTH INFORMATION**
3 **TECHNOLOGY.**

4 “(a) COMPETITIVE GRANTS FOR ADOPTION OF
5 TECHNOLOGY.—

6 “(1) IN GENERAL.—The Secretary may award
7 competitive grants to eligible entities to facilitate the
8 purchase and enhance the utilization of qualified
9 health information technology systems to improve
10 the quality and efficiency of health care.

11 “(2) ELIGIBILITY.—To be eligible to receive a
12 grant under paragraph (1) an entity shall—

13 “(A) submit to the Secretary an applica-
14 tion at such time, in such manner, and con-
15 taining such information as the Secretary may
16 require;

17 “(B) submit to the Secretary a strategic
18 plan for the implementation of data sharing
19 and interoperability measures;

20 “(C) adopt the standards adopted by the
21 Federal Government under section 3005;

22 “(D) implement the measures adopted
23 under section 3010 and report to the Secretary
24 on such measures;

1 “(E) agree to notify individuals if their in-
2 dividually identifiable health information is
3 wrongfully disclosed;

4 “(F) take into account the input of em-
5 ployees and staff who are directly involved in
6 patient care of such health care providers in the
7 design, implementation, and use of qualified
8 health information technology systems;

9 “(G) demonstrate significant financial
10 need;

11 “(H) provide matching funds in accord-
12 ance with paragraph (4); and

13 “(I) be a—

14 “(i) public or not for profit hospital;

15 “(ii) federally qualified health center
16 (as defined in section 1861(aa)(4) of the
17 Social Security Act);

18 “(iii) individual or group practice (or
19 a consortium thereof); or

20 “(iv) another health care provider not
21 described in clause (i) or (ii);

22 that serves medically underserved communities.

23 “(3) USE OF FUNDS.—Amounts received under
24 a grant under this subsection shall be used to—

1 “(A) facilitate the purchase of qualified
2 health information technology systems;

3 “(B) train personnel in the use of such
4 systems;

5 “(C) enhance the utilization of qualified
6 health information technology systems (which
7 may include activities to increase the awareness
8 among consumers of health care privacy protec-
9 tions); or

10 “(D) improve the prevention and manage-
11 ment of chronic disease.

12 “(4) MATCHING REQUIREMENT.—To be eligible
13 for a grant under this subsection an entity shall con-
14 tribute non-Federal contributions to the costs of car-
15 rying out the activities for which the grant is award-
16 ed in an amount equal to \$1 for each \$3 of Federal
17 funds provided under the grant.

18 “(5) PREFERENCE IN AWARDING GRANTS.—In
19 awarding grants under this subsection the Secretary
20 shall give preference to—

21 “(A) eligible entities that will improve the
22 degree to which such entity will link the quali-
23 fied health information system to local or re-
24 gional health information plan or plans; and

“(B) with respect to awards made for the purpose of providing care in an outpatient medical setting, entities that organize their practices as a patient-centered medical home.

“(b) COMPETITIVE GRANTS FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDE-SPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

“(1) IN GENERAL.—The Secretary may award competitive grants to States for the establishment of State programs for loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology.

“(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a ‘State loan fund’) and comply with the other requirements contained in this subsection. Amounts received under a grant under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any such State loan fund.

1 “(3) ELIGIBILITY.—To be eligible to receive a
2 grant under paragraph (1) a State shall—

3 “(A) submit to the Secretary an applica-
4 tion at such time, in such manner, and con-
5 taining such information as the Secretary may
6 require;

7 “(B) submit to the Secretary a strategic
8 plan in accordance with paragraph (4);

9 “(C) establish a qualified health informa-
10 tion technology loan fund in accordance with
11 paragraph (2);

12 “(D) require that health care providers re-
13 ceiving loans under the grant—

14 “(i) link, to the extent practicable, the
15 qualified health information system to a
16 local or regional health information net-
17 work;

18 “(ii) consult, as needed, with the
19 Health Information Technology Resource
20 Center established in section 914(d) to ac-
21 cess the knowledge and experience of exist-
22 ing initiatives regarding the successful im-
23 plementation and effective use of health in-
24 formation technology;

1 “(iii) agree to notify individuals if
2 their individually identifiable health infor-
3 mation is wrongfully disclosed; and

4 “(iv) take into account the input of
5 employees and staff who are directly in-
6 volved in patient care of such health care
7 providers in the design and implementation
8 and use of qualified health information
9 technology systems;

10 “(E) require that health care providers re-
11 ceiving loans under the grant adopt the stand-
12 ards adopted by the Federal Government under
13 section 3005;

14 “(F) require that health care providers re-
15 ceiving loans under the grant implement the
16 measures adopted under section 3010 and re-
17 port to the Secretary on such measures; and

18 “(G) provide matching funds in accordance
19 with paragraph (8).

20 “(4) STRATEGIC PLAN.—

21 “(A) IN GENERAL.—A State that receives
22 a grant under this subsection shall annually
23 prepare a strategic plan that identifies the in-
24 tended uses of amounts available to the State
25 loan fund of the State.

1 “(B) CONTENTS.—A strategic plan under
2 subparagraph (A) shall include—

3 “(i) a list of the projects to be as-
4 sisted through the State loan fund in the
5 first fiscal year that begins after the date
6 on which the plan is submitted;

7 “(ii) a description of the criteria and
8 methods established for the distribution of
9 funds from the State loan fund;

10 “(iii) a description of the financial
11 status of the State loan fund and the
12 short-term and long-term goals of the
13 State loan fund; and

14 “(iv) a description of the strategies
15 the State will use to address challenges in
16 the adoption of health information tech-
17 nology due to limited broadband access.

18 “(5) USE OF FUNDS.—

19 “(A) IN GENERAL.—Amounts deposited in
20 a State loan fund, including loan repayments
21 and interest earned on such amounts, shall be
22 used only for awarding loans or loan guaran-
23 tees, or as a source of reserve and security for
24 leveraged loans, the proceeds of which are de-
25 posited in the State loan fund established under

1 paragraph (1). Loans under this section may be
2 used by a health care provider to—

3 “(i) facilitate the purchase of qualified
4 health information technology systems;

5 “(ii) enhance the utilization of quali-
6 fied health information technology systems
7 (which may include activities to increase
8 the awareness among consumers of health
9 care of privacy protections and privacy
10 rights); or

11 “(iii) train personnel in the use of
12 such systems.

13 “(B) LIMITATION.—Amounts received by a
14 State under this subsection may not be used—

15 “(i) for the purchase or other acquisi-
16 tion of any health information technology
17 system that is not a qualified health infor-
18 mation technology system;

19 “(ii) to conduct activities for which
20 Federal funds are expended under this
21 title, or the amendments made by the
22 Wired for Health Care Quality Act; or

23 “(iii) for any purpose other than mak-
24 ing loans to eligible entities under this sec-
25 tion.

1 “(6) TYPES OF ASSISTANCE.—Except as other-
2 wise limited by applicable State law, amounts depos-
3 ited into a State loan fund under this subsection
4 may only be used for the following:

5 “(A) To award loans that comply with the
6 following:

7 “(i) The interest rate for each loan
8 shall be less than or equal to the market
9 interest rate.

10 “(ii) The principal and interest pay-
11 ments on each loan shall commence not
12 later than 1 year after the date on which
13 the loan was awarded, and each loan shall
14 be fully amortized not later than 10 years
15 after such date.

16 “(iii) The State loan fund shall be
17 credited with all payments of principal and
18 interest on each loan awarded from the
19 fund.

20 “(B) To guarantee, or purchase insurance
21 for, a local obligation (all of the proceeds of
22 which finance a project eligible for assistance
23 under this subsection) if the guarantee or pur-
24 chase would improve credit market access or re-

duce the interest rate applicable to the obligation involved.

“(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.

“(D) To earn interest on the amounts deposited into the State loan fund.

“(7) ADMINISTRATION OF STATE LOAN FUNDS.—

“(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if not otherwise prohibited by the law under which the State loan fund was established.

“(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to the State under a grant under this subsection to pay the

1 reasonable costs of the administration of the
2 programs under this section, including the re-
3 covery of reasonable costs expended to establish
4 a State loan fund which are incurred after the
5 date of enactment of this title.

6 “(C) GUIDANCE AND REGULATIONS.—The
7 Secretary shall publish guidance and promul-
8 gate regulations as may be necessary to carry
9 out the provisions of this subsection, includ-
10 ing—

11 “(i) provisions to ensure that each
12 State commits and expends funds allotted
13 to the State under this subsection as effi-
14 ciently as possible in accordance with this
15 title and applicable State laws; and

16 “(ii) guidance to prevent waste, fraud,
17 and abuse.

18 “(D) PRIVATE SECTOR CONTRIBUTIONS.—

19 “(i) IN GENERAL.—A State loan fund
20 established under this subsection may ac-
21 cept contributions from private sector enti-
22 ties, except that such entities may not
23 specify the recipient or recipients of any
24 loan issued under this subsection.

1 “(ii) AVAILABILITY OF INFORMA-
2 TION.—A State shall make publicly avail-
3 able the identity of, and amount contrib-
4 uted by, any private sector entity under
5 clause (i) and may issue letters of com-
6 mendation or make other awards (that
7 have no financial value) to any such entity.

8 “(8) MATCHING REQUIREMENTS.—

9 “(A) IN GENERAL.—The Secretary may
10 not make a grant under paragraph (1) to a
11 State unless the State agrees to make available
12 (directly or through donations from public or
13 private entities) non-Federal contributions in
14 cash toward the costs of the State program to
15 be implemented under the grant in an amount
16 equal to not less than \$1 for each \$1 of Federal
17 funds provided under the grant.

18 “(B) DETERMINATION OF AMOUNT OF
19 NON-FEDERAL CONTRIBUTION.—In determining
20 the amount of non-Federal contributions that a
21 State has provided pursuant to subparagraph
22 (A), the Secretary may not include any
23 amounts provided to the State by the Federal
24 Government.

1 “(9) PREFERENCE IN AWARDING GRANTS.—

2 The Secretary may give a preference in awarding
3 grants under this subsection to States that adopt
4 value-based purchasing programs to improve health
5 care quality.

6 “(10) REPORTS.—The Secretary shall annually
7 submit to the Committee on Health, Education,
8 Labor, and Pensions and the Committee on Finance
9 of the Senate, and the Committee on Energy and
10 Commerce and the Committee on Ways and Means
11 of the House of Representatives, a report summa-
12 rizing the reports received by the Secretary from
13 each State that receives a grant under this sub-
14 section.

15 “(c) COMPETITIVE GRANTS FOR THE IMPLEMENTA-
16 TION OF REGIONAL OR LOCAL HEALTH INFORMATION
17 TECHNOLOGY PLANS.—

18 “(1) IN GENERAL.—The Secretary may award
19 competitive grants to eligible entities to implement
20 regional or local health information plans to improve
21 health care quality and efficiency through the elec-
22 tronic exchange of health information pursuant to
23 the standards, implementation specifications and
24 certification criteria, and other requirements adopted
25 by the Secretary under section 3010.

1 “(2) ELIGIBILITY.—To be eligible to receive a
2 grant under paragraph (1) an entity shall—

3 “(A) demonstrate financial need to the
4 Secretary;

5 “(B) demonstrate that one of its principal
6 missions or purposes is to use information tech-
7 nology to improve health care quality and effi-
8 ciency;

9 “(C) adopt bylaws, memoranda of under-
10 standing, or other charter documents that dem-
11 onstrate that the governance structure and de-
12 cisionmaking processes of such entity allow for
13 participation on an ongoing basis by multiple
14 stakeholders within a community, including—

15 “(i) health care providers (including
16 health care providers that provide services
17 to low income and underserved popu-
18 lations);

19 “(ii) pharmacists or pharmacies;

20 “(iii) health plans;

21 “(iv) health centers (as defined in sec-
22 tion 330(b)) and federally qualified health
23 centers (as defined in section 1861(aa)(4)
24 of the Social Security Act) and rural
25 health clinics (as defined in section

1 1861(aa) of the Social Security Act), if
2 such centers or clinics are present in the
3 community served by the entity;

4 “(v) patient or consumer organiza-
5 tions;

6 “(vi) organizations dedicated to im-
7 proving the health of vulnerable popu-
8 lations;

9 “(vii) employers;

10 “(viii) State or local health depart-
11 ments; and

12 “(ix) any other health care providers
13 or other entities, as determined appro-
14 priate by the Secretary;

15 “(D) demonstrate the participation, to the
16 extent practicable, of stakeholders in the elec-
17 tronic exchange of health information within
18 the local or regional plan pursuant to subpara-
19 graph (C);

20 “(E) adopt nondiscrimination and conflict
21 of interest policies that demonstrate a commit-
22 ment to open, fair, and nondiscriminatory par-
23 ticipation in the health information plan by all
24 stakeholders;

1 “(F) adopt the standards adopted by the
2 Secretary under section 3005;

3 “(G) require that health care providers re-
4 ceiving such grants—

5 “(i) implement the measures adopted
6 under section 3010 and report to the Sec-
7 retary on such measures; and

8 “(ii) take into account the input of
9 employees and staff who are directly in-
10 volved in patient care of such health care
11 providers in the design, implementation,
12 and use of health information technology
13 systems;

14 “(H) agree to notify individuals if their in-
15 dividually identifiable health information is
16 wrongfully disclosed;

17 “(I) facilitate the electronic exchange of
18 health information within the local or regional
19 area and among local and regional areas;

20 “(J) prepare and submit to the Secretary
21 an application in accordance with paragraph
22 (3);

23 “(K) agree to provide matching funds in
24 accordance with paragraph (5); and

1 “(L) reduce barriers to the implementation
2 of health information technology by providers.

3 “(3) APPLICATION.—

4 “(A) IN GENERAL.—To be eligible to re-
5 ceive a grant under paragraph (1), an entity
6 shall submit to the Secretary an application at
7 such time, in such manner, and containing such
8 information as the Secretary may require.

9 “(B) REQUIRED INFORMATION.—At a
10 minimum, an application submitted under this
11 paragraph shall include—

12 “(i) clearly identified short-term and
13 long-term objectives of the regional or local
14 health information plan;

15 “(ii) a technology plan that complies
16 with the standards, implementation speci-
17 fications, and certification criteria adopted
18 under section 3003(c)(6) and that includes
19 a descriptive and reasoned estimate of
20 costs of the hardware, software, training,
21 and consulting services necessary to imple-
22 ment the regional or local health informa-
23 tion plan;

24 “(iii) a strategy that includes initia-
25 tives to improve health care quality and ef-

1 iciency, including the use and reporting of
2 health care quality measures adopted
3 under section 3010;

4 “(iv) a plan that describes provisions
5 to encourage the implementation of the
6 electronic exchange of health information
7 by all health care providers participating in
8 the health information plan;

9 “(v) a plan to ensure the privacy and
10 security of individually identifiable health
11 information that is consistent with Federal
12 and State law;

13 “(vi) a governance plan that defines
14 the manner in which the stakeholders shall
15 jointly make policy and operational deci-
16 sions on an ongoing basis;

17 “(vii) a financial or business plan that
18 describes—

19 “(I) the sustainability of the
20 plan;

21 “(II) the financial costs and ben-
22 efits of the plan; and

23 “(III) the entities to which such
24 costs and benefits will accrue;

1 “(viii) a description of whether the
2 State in which the entity resides has re-
3 ceived a grant under section 319D, alone
4 or as a part of a consortium, and if the
5 State has received such a grant, how the
6 entity will coordinate the activities funded
7 under such section 319D with the system
8 under this section; and

9 “(ix) in the case of an applicant entity
10 that is unable to demonstrate the partici-
11 pation of all stakeholders pursuant to
12 paragraph (2)(C), the justification from
13 the entity for any such nonparticipation.

14 “(4) USE OF FUNDS.—Amounts received under
15 a grant under paragraph (1) shall be used to estab-
16 lish and implement a regional or local health infor-
17 mation plan in accordance with this subsection.

18 “(5) MATCHING REQUIREMENT.—

19 “(A) IN GENERAL.—The Secretary may
20 not make a grant under this subsection to an
21 entity unless the entity agrees that, with re-
22 spect to the costs to be incurred by the entity
23 in carrying out the infrastructure program for
24 which the grant was awarded, the entity will
25 make available (directly or through donations

1 from public or private entities) non-Federal
2 contributions toward such costs in an amount
3 equal to not less than 50 percent of such costs
4 (\$1 for each \$2 of Federal funds provided
5 under the grant).

6 “(B) DETERMINATION OF AMOUNT CON-
7 TRIBUTED.—Non-Federal contributions re-
8 quired under subparagraph (A) may be in cash
9 or in kind, fairly evaluated, including equip-
10 ment, technology, or services. Amounts provided
11 by the Federal Government, or services assisted
12 or subsidized to any significant extent by the
13 Federal Government, may not be included in
14 determining the amount of such non-Federal
15 contributions.

16 “(d) REPORTS.—Not later than 1 year after the date
17 on which the first grant is awarded under this section,
18 and annually thereafter during the grant period, an entity
19 that receives a grant under this section shall submit to
20 the Secretary a report on the activities carried out under
21 the grant involved. Each such report shall include—

22 “(1) a description of the financial costs and
23 benefits of the project involved and of the entities to
24 which such costs and benefits accrue;

1 “(2) an analysis of the impact of the project on
2 health care quality and safety;

3 “(3) a description of any reduction in duplica-
4 tive or unnecessary care as a result of the project in-
5 volved; and

6 “(4) other information as required by the Sec-
7 retary.

8 “(e) AUTHORIZATION OF APPROPRIATIONS.—

9 “(1) IN GENERAL.—For the purpose of car-
10 rying out this section, there is authorized to be ap-
11 propriated \$139,000,000 for fiscal year 2008 and
12 \$139,000,000 for fiscal year 2009.

13 “(2) AVAILABILITY.—Amounts appropriated
14 under paragraph (1) shall remain available through
15 fiscal year 2012.

16 **“SEC. 3009. DEMONSTRATION PROGRAM TO INTEGRATE IN-**
17 **FORMATION TECHNOLOGY INTO CLINICAL**
18 **EDUCATION.**

19 “(a) IN GENERAL.—The Secretary may award grants
20 to eligible entities or consortia under this section to carry
21 out demonstration projects to develop academic curricula
22 integrating qualified health information technology sys-
23 tems in the clinical education of health professionals or
24 analyze clinical data sets to discover quality measures.

1 Such awards shall be made on a competitive basis and
2 pursuant to peer review.

3 “(b) ELIGIBILITY.—To be eligible to receive a grant
4 under subsection (a), an entity or consortium shall—

5 “(1) submit to the Secretary an application at
6 such time, in such manner, and containing such in-
7 formation as the Secretary may require;

8 “(2) be or include—

9 “(A) a health professions school;

10 “(B) a school of nursing; or

11 “(C) an institution with a graduate med-
12 ical education program;

13 “(3) provide for the collection of data regarding
14 the effectiveness of the demonstration project to be
15 funded under the grant in improving the safety of
16 patients and the efficiency of health care delivery;
17 and

18 “(4) provide matching funds in accordance with
19 subsection (d).

20 “(c) USE OF FUNDS.—

21 “(1) IN GENERAL.—With respect to a grant
22 under subsection (a), an eligible entity or consortium
23 shall use amounts received under the grant in col-
24 laboration with 2 or more disciplines.

1 “(2) LIMITATION.—An eligible entity or consor-
2 tium shall not award a grant under subsection (a)
3 to purchase hardware, software, or services.

4 “(d) MATCHING FUNDS.—

5 “(1) IN GENERAL.—The Secretary may award
6 a grant to an entity under or consortium this section
7 only if the entity of consortium agrees to make avail-
8 able non-Federal contributions toward the costs of
9 the program to be funded under the grant in an
10 amount that is not less than \$1 for each \$2 of Fed-
11 eral funds provided under the grant.

12 “(2) DETERMINATION OF AMOUNT CONTRIB-
13 UTED.—Non-Federal contributions under paragraph
14 (1) may be in cash or in kind, fairly evaluated, in-
15 cluding equipment or services. Amounts provided by
16 the Federal Government, or services assisted or sub-
17 sidized to any significant extent by the Federal Gov-
18 ernment, may not be included in determining the
19 amount of such contributions.

20 “(e) EVALUATION.—The Secretary shall take such
21 action as may be necessary to evaluate the projects funded
22 under this section and publish, make available, and dis-
23 seminate the results of such evaluations on as wide a basis
24 as is practicable.

1 “(f) REPORTS.—Not later than 1 year after the date
 2 of enactment of this title, and annually thereafter, the Sec-
 3 retary shall submit to the Committee on Health, Edu-
 4 cation, Labor, and Pensions and the Committee on Fi-
 5 nance of the Senate, and the Committee on Energy and
 6 Commerce and the Committee on Ways and Means of the
 7 House of Representatives a report that—

8 “(1) describes the specific projects established
 9 under this section; and

10 “(2) contains recommendations for Congress
 11 based on the evaluation conducted under subsection
 12 (e).

13 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 14 is authorized to be appropriated to carry out this section,
 15 \$2,000,000 for each of fiscal years 2008 and 2009.

16 “(h) SUNSET.—This provisions of this section shall
 17 not apply after September 30, 2012.”.

18 **Subpart C—Improving the Quality of Health Care**

19 **SEC. 311. CONSENSUS PROCESS FOR THE ADOPTION OF**
 20 **QUALITY MEASURES FOR USE IN THE NA-**
 21 **TIONWIDE INTEROPERABLE HEALTH INFOR-**
 22 **MATION TECHNOLOGY INFRASTRUCTURE.**

23 Title XXX of the Public Health Service Act, as
 24 amended by section 305, is further amended by adding
 25 at the end the following:

1 **“SEC. 3010. FOSTERING DEVELOPMENT AND USE OF**
2 **HEALTH CARE QUALITY MEASURES.**

3 “(a) IN GENERAL.—The Secretary shall provide for
4 the development and use of health care quality measures
5 (referred to in this title as ‘quality measures’) for the pur-
6 pose of measuring the quality and efficiency of health care
7 that patients receive.

8 “(b) DESIGNATION OF, AND ARRANGEMENT WITH,
9 ORGANIZATION.—

10 “(1) IN GENERAL.—Not later than 90 days
11 after the date of enactment of this title, the Sec-
12 retary shall designate, and have in effect an ar-
13 rangement with, a single organization that meets the
14 requirements of subsection (c) under which such or-
15 ganization shall promote the development of quality
16 measures and provide the Secretary with advice and
17 recommendations on the key elements and priorities
18 of a national system for healthcare performance
19 measurement.

20 “(2) RESPONSIBILITIES.—The responsibilities
21 to be performed by the organization designated
22 under paragraph (1) (in this title referred to as the
23 ‘designated organization’) shall include—

24 “(A) establishing and managing an inte-
25 grated national strategy and process for setting

1 priorities and goals in establishing quality
2 measures;

3 “(B) coordinating and harmonizing the de-
4 velopment and testing of such measures;

5 “(C) establishing standards for the devel-
6 opment and testing of such measures;

7 “(D) endorsing national consensus quality
8 measures;

9 “(E) recommending, in collaboration with
10 multi-stakeholder groups, quality measures to
11 the Secretary for adoption and use;

12 “(F) promoting the development and use
13 of electronic health records that contain the
14 functionality for automated collection, aggrega-
15 tion, and transmission of performance measure-
16 ment information; and

17 “(G) providing recommendations and ad-
18 vice to the Partnership regarding the integra-
19 tion of quality measures into the certification
20 process outlined under section 3003 and the
21 Community regarding national policies outlined
22 under section 3004.

23 “(c) REQUIREMENTS DESCRIBED.—The require-
24 ments described in this subsection are the following:

1 “(1) PRIVATE ENTITY.—The organization shall
2 be a private nonprofit entity that is governed by a
3 board of directors and an individual who is des-
4 ignated as president and chief executive officer.

5 “(2) BOARD MEMBERSHIP.—The members of
6 the board of directors of the entity shall include rep-
7 resentatives of—

8 “(A) health care providers or groups rep-
9 resenting providers;

10 “(B) health plans or groups representing
11 health plans;

12 “(C) patients or consumers enrolled in
13 such plans or groups representing individuals
14 enrolled in such plans;

15 “(D) health care purchasers and employers
16 or groups representing purchasers or employers;
17 and

18 “(E) organizations that develop health in-
19 formation technology standards and new health
20 information technology.

21 “(3) OTHER MEMBERSHIP REQUIREMENTS.—
22 The membership of the board of directors of the en-
23 tity shall be representative of individuals with expe-
24 rience with—

25 “(A) urban health care issues;

1 “(B) safety net health care issues;

2 “(C) rural or frontier health care issues;

3 “(D) quality and safety issues;

4 “(E) State or local health programs;

5 “(F) individuals or entities skilled in the
6 conduct and interpretation of biomedical, health
7 services, and health economics research and
8 with expertise in outcomes and effectiveness re-
9 search and technology assessment; and

10 “(G) individuals or entities involved in the
11 development and establishment of standards
12 and certification for health information tech-
13 nology systems and clinical data.

14 “(4) OPEN AND TRANSPARENT.—With respect
15 to matters related to the arrangement with the Sec-
16 retary under subsection (a)(1), the organization
17 shall conduct its business in an open and trans-
18 parent manner, and provide the opportunity for pub-
19 lic comment and ensure a balance among disparate
20 stakeholders, so that no member organization unduly
21 influences the work of the organization.

22 “(5) VOLUNTARY CONSENSUS STANDARDS SET-
23 TING ORGANIZATIONS.—The organization shall oper-
24 ate as a voluntary consensus standards setting orga-
25 nization as defined for purposes of section 12(d) of

1 the National Technology Transfer and Advancement
 2 Act of 1995 (Public Law 104–113) and Office of
 3 Management and Budget Revised Circular A-119
 4 (published in the Federal Register on February 10,
 5 1998).

6 “(6) PARTICIPATION.—If the organization re-
 7 quires a fee for membership, the organization shall
 8 ensure that such fee is not a substantial barrier to
 9 participation in the entity’s activities related to the
 10 arrangement with the Secretary.

11 “(d) REQUIREMENTS FOR MEASURES.—The quality
 12 measures developed under this title shall comply with the
 13 following:

14 “(1) MEASURES.—The designated organization,
 15 in promoting the development of quality measures
 16 under this title, shall ensure that such measures—

17 “(A) are evidence-based, reliable, and
 18 valid;

19 “(B) include—

20 “(i) measures of clinical processes and
 21 outcomes, patient experience, efficiency,
 22 and equity; and

23 “(ii) measures to assess effectiveness,
 24 timeliness, patient self-management, pa-
 25 tient centeredness, and safety; and

“(C) include measures of underuse and overuse.

“(2) PRIORITIES.—In carrying out its responsibilities under this section, the designated organization shall ensure that priority is given to—

“(A) measures with the greatest potential impact for improving the performance and efficiency of care;

“(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers;

“(C) measures which may inform health care decisions made by consumers and patients;

“(D) measures that apply to multiple services furnished by different providers during an episode of care;

“(E) measures that can be integrated into certification process described in section 3003; and

“(F) measures that may be integrated into the decision support function of qualified health information technology as defined by this title.

“(3) RISK ADJUSTMENT.—The designated organization, in consultation with performance measure

1 developers and other stakeholders, shall establish
2 procedures to ensure that quality measures take into
3 account differences in patient health status, patient
4 characteristics, and geographic location, as appropriate.
5

6 “(4) MAINTENANCE.—The designated organiza-
7 tion, in consultation with owners and developers of
8 quality measures, shall require the owners or devel-
9 opers of quality measures to update and enhance
10 such measures, including the development of more
11 accurate and precise specifications, and retire exist-
12 ing outdated measures. Such updating shall occur
13 not more often than once during each 12-month pe-
14 riod, except in the case of emergency circumstances
15 requiring a more immediate update to a measure.

16 “(e) GRANTS FOR PERFORMANCE MEASURE DEVEL-
17 OPMENT.—The Secretary, acting through the Agency for
18 Healthcare Research and Quality, may award grants, in
19 amounts not to exceed \$50,000 each, to organizations to
20 support the development and testing of quality measures
21 that meet the standards established by the designated or-
22 ganization.

1 **“SEC. 3011. ADOPTION AND USE OF QUALITY MEASURES;**
2 **REPORTING.**

3 “(a) IN GENERAL.—For purposes of carrying out ac-
4 tivities authorized or required by this title to ensure the
5 use of quality measures and to foster uniformity between
6 health care quality measures utilized by private entities,
7 the Secretary shall—

8 “(1) select quality measures for adoption and
9 use, from quality measures recommended by multi-
10 stakeholder groups and endorsed by the designated
11 organization; and

12 “(2) ensure that standards adopted under sec-
13 tion 3005 integrate the quality measures endorsed,
14 adopted, and utilized under this section.

15 “(b) RELATIONSHIP WITH PROGRAMS UNDER THE
16 SOCIAL SECURITY ACT.—The Secretary shall ensure that
17 the quality measures adopted under this section—

18 “(1) complement quality measures developed by
19 the Secretary under programs administered by the
20 Secretary under the Social Security Act, including
21 programs under titles XVIII, XIX, and XXI of such
22 Act; and

23 “(2) do not conflict with the needs and prior-
24 ities of the programs under titles XVIII, XIX, and
25 XXI of such Act, as set forth by the Administrator
26 of the Centers for Medicare & Medicaid Services.

1 “(c) REPORTING.—The Secretary shall implement
 2 procedures, consistent with generally accepted standards,
 3 to enable the Department of Health and Human Services
 4 to accept the electronic submission of data for purposes
 5 of performance measurement, including at the provider
 6 level, using the quality measures developed, endorsed, and
 7 adopted pursuant to this title.

8 “(d) DISSEMINATION OF INFORMATION.—In order to
 9 make comparative performance information available to
 10 health care consumers, health professionals, public health
 11 officials, oversight organizations, researchers, and other
 12 appropriate individuals and entities, after consultation
 13 with multi-stakeholder groups, the Secretary shall promul-
 14 gate regulations to provide for the dissemination, aggrega-
 15 tion, and analysis of quality measures collected pursuant
 16 to this title.”.

17 **Subpart D—Privacy and Security**

18 **SEC. 321. PRIVACY AND SECURITY.**

19 Title XXX of the Public Health Service Act, as
 20 amended by section 311, is further amended by adding
 21 at the end the following:

22 **“SEC. 3013. ENSURING PRIVACY AND SECURITY.**

23 “(a) PRIVACY PROTECTIONS APPLY TO HEALTH IN-
 24 FORMATION ELECTRONIC DATABASES.—An operator of a
 25 health information electronic database shall be deemed to

1 be a ‘covered entity’ for purposes of sections 1171 through
2 1179 of the Social Security Act and the regulations pro-
3 mulgated under section 264(c) of the Health Insurance
4 Portability and Accountability Act of 1996 (42 U.S.C.
5 1320d-2 note) (referred to in this section as the ‘HIPAA
6 privacy regulations’.

7 “(b) HEALTH INFORMATION ELECTRONIC DATABASE
8 DEFINED.—In this section, the term ‘operator of a health
9 information electronic database’ means an entity that—

10 “(1) is constituted, organized, or chartered for
11 the primary purpose of maintaining or transmitting
12 protected health information in a designated record
13 set or sets;

14 “(2) receives valuable consideration for main-
15 taining or transmitting protected health information
16 in a designated record set or sets; and

17 “(3) is not a health plan, healthcare clearing-
18 house, or healthcare provider who transmits any
19 health information in electronic form in connection
20 with a transaction referred to in section 1173(a)(1)
21 of the Social Security Act.

22 “(c) RIGHT OF INDIVIDUALS TO INSPECT THEIR
23 MEDICAL RECORDS MAINTAINED IN ELECTRONIC FOR-
24 MAT.—To the extent provided for under the HIPAA pri-
25 vacy regulations with respect to protected health informa-

1 tion, an individual shall have a right of access to inspect
2 and obtain a copy of protected health information about
3 the individual stored in electronic format.

4 “(d) RIGHTS OF INDIVIDUALS WHO ARE VICTIMS OF
5 MEDICAL FRAUD.—To the extent provided for under the
6 HIPAA privacy regulations and under the conditions spec-
7 ified in such regulations, with respect to protected health
8 information, an individual who is a victim of medical fraud
9 or who believes that there is an error in their protected
10 health information stored in an electronic format shall
11 have the right—

12 “(1) to have access to inspect and obtain a copy
13 of protected health information about the individual,
14 including the information fraudulently entered, in a
15 designated record set; and

16 “(2) to have a covered entity amend protected
17 health information or a record about the individual,
18 including information fraudulently entered, in a des-
19 ignated electronic record set for as long as the pro-
20 tected health information is maintained in the des-
21 ignated electronic record set to ensure that fraudu-
22 lent and inaccurate health information is not shared
23 or re-reported.

24 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
25 tion shall be construed to supercede or otherwise limit the

1 provisions of any contract that provides for the application
2 of privacy protections that are greater than the privacy
3 protections provided for under the regulations promul-
4 gated under section 264 of the Health Insurance Port-
5 ability and Accountability Act of 1996.”.

6 **Subpart E—Miscellaneous Provisions**

7 **SEC. 331. GAO STUDY.**

8 Not later than 12 months after the date of enactment
9 of this Act, the Comptroller General of the United States
10 shall submit to Congress a report on the circumstances
11 in which it is necessary and workable to require health
12 plans (as defined in section 1171 of the Social Security
13 Act (42 U.S.C. 1320d)), health care clearinghouses (as de-
14 fined in such section 1171), and health care providers (as
15 defined in such section 1171) who transmit health infor-
16 mation in electronic form, to notify individuals if their in-
17 dividually identifiable health information (as defined in
18 such section 1171) is wrongfully disclosed.

19 **SEC. 332. HEALTH INFORMATION TECHNOLOGY RESOURCE** 20 **CENTER.**

21 Section 914 of the Public Health Service Act (42
22 U.S.C. 299b–3) is amended by adding at the end the fol-
23 lowing:

24 “(d) HEALTH INFORMATION TECHNOLOGY RE-
25 SOURCE CENTER.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Director, shall develop a Health Infor-
3 mation Technology Resource Center (referred to in
4 this subsection as the ‘Center’) to provide technical
5 assistance and develop best practices to support and
6 accelerate efforts to adopt, implement, and effec-
7 tively use interoperable health information tech-
8 nology in compliance with sections 3003 and 3010.

9 “(2) PURPOSES.—The purposes of the Center
10 are to—

11 “(A) provide a forum for the exchange of
12 knowledge and experience;

13 “(B) accelerate the transfer of lessons
14 learned from existing public and private sector
15 initiatives, including those currently receiving
16 Federal financial support;

17 “(C) assemble, analyze, and widely dis-
18 seminate evidence and experience related to the
19 adoption, implementation, and effective use of
20 interoperable health information technology;

21 “(D) provide for the establishment of re-
22 gional and local health information networks to
23 facilitate the development of interoperability
24 across health care settings and improve the
25 quality of health care;

“(E) provide for the development of solutions to barriers to the exchange of electronic health information; and

“(F) conduct other activities identified by the States, local, or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.

“(3) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.

“(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the duplication of Federal efforts with respect to the establishment of the Center, regardless of whether such efforts were carried out prior to or after the enactment of this subsection.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2008 and 2009 to carry out this section.”.

1 **SEC. 333. FACILITATING THE PROVISION OF TELEHEALTH**
2 **SERVICES ACROSS STATE LINES.**

3 Section 330L of the Public Health Service Act (42
4 U.S.C. 254c-18) is amended to read as follows:

5 **“SEC. 330L. TELEMEDICINE; INCENTIVE GRANTS REGARD-**
6 **ING COORDINATION AMONG STATES.**

7 “(a) FACILITATING THE PROVISION OF TELE-
8 HEALTH SERVICES ACROSS STATE LINES.—The Sec-
9 retary may make grants to States that have adopted re-
10 gional State reciprocity agreements for practitioner licen-
11 sure, in order to expedite the provision of telehealth serv-
12 ices across State lines.

13 “(b) AUTHORIZATION OF APPROPRIATIONS.—For the
14 purpose of carrying out subsection (a), there are author-
15 ized to be appropriated such sums as may be necessary
16 for each of the fiscal years 2008 and 2009.”.

17 **PART II—MAKING HEALTH CARE MORE**
18 **ACCESSIBLE FOR ALL AMERICANS**

19 **SEC. 341. REAUTHORIZATION OF CERTAIN TELEHEALTH**
20 **PROGRAMS.**

21 (a) TELEHEALTH NETWORK AND TELEHEALTH RE-
22 SOURCE CENTERS GRANT PROGRAMS.—Section 330I(s)
23 of the Public Health Service Act (42 U.S.C. 254c-14(s))
24 is amended—

25 (1) in paragraph (1), by striking “2006” and
26 inserting “2012”; and

(2) in paragraph (2), by striking “2006” and inserting “2012”.

(b) RURAL EMERGENCY MEDICAL SERVICE TRAINING AND EQUIPMENT ASSISTANCE PROGRAM.—Section 330J(g)(1) of the Public Health Service Act (42 U.S.C. 254c–15(g)(1)) is amended by striking “2006” and inserting “2012”.

(c) MENTAL HEALTH SERVICES DELIVERED VIA TELEHEALTH.—Section 330K(g) of the Public Health Service Act (42 U.S.C. 254c–16(g)) is amended by striking “2006” and inserting “2012”.

SEC. 342. QUALITY IMPROVEMENT ACTIVITIES.

Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

“(18) The organization shall offer quality improvement assistance to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII, and prescription drug sponsors offering prescription drug plans under part D of such title, including the following:

“(A) Education on quality improvement initiatives, strategies, and techniques.

1 “(B) Instruction on how to collect, submit,
2 aggregate, and interpret data on measures that
3 may be used for quality improvement, public re-
4 porting, and payment.

5 “(C) Technical assistance for providers
6 and practitioners in beneficiary education to fa-
7 cilitate patient self-management.

8 “(D) Guidance on redesigning clinical
9 processes, including the adoption and effective
10 use of health information technology, to im-
11 prove the coordination, effectiveness, and safety
12 of care.

13 “(E) Assistance in improving the quality of
14 care delivered in rural and frontier areas, in-
15 cluding efforts to prevent or address any incon-
16 sistencies or delays in the rate of adoption of
17 health information technology and in the effec-
18 tive use of such technology among entities that
19 furnish such services in rural areas.

20 “(F) Assistance in improving coordination
21 of care as patients transition between providers
22 and practitioners, including developing the ca-
23 pacity to securely exchange electronic health in-
24 formation and helping providers and practi-

tioners to effectively use secure electronic health information to improve quality.”.

**SEC. 343. SENSE OF THE SENATE REGARDING PHYSICIAN
PAYMENTS UNDER MEDICARE.**

It is the sense of the Senate that modifications to the Medicare fee schedule for physicians’ services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) should include provisions based on the reporting of quality measures pursuant to those adopted in section 3010 of the Public Health Service Act (as added by section 305) and the overall improvement of health care quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 3003 of such Act (as added by section 301.

**Subtitle B—Increasing Access to
Physicians and Nurses**

**SEC. 351. REAUTHORIZATION OF PROGRAMS AND MIS-
CELLANEOUS AMENDMENTS.**

(a) HEALTH PROFESSIONS EDUCATION PROGRAMS.—Part F of title VII of the Public Health Service Act (42 U.S.C. 295j et seq.) is amended by adding at the end the following:

1 **“SEC. 799C. GENERAL AUTHORIZATION OF APPROPRIA-**
2 **TIONS.**

3 “(a) IN GENERAL.—Notwithstanding any other pro-
4 vision of this title, beginning with fiscal year 2008, there
5 is authorized to be appropriated to carry out this title,
6 such sums as may be necessary for each of fiscal years
7 2008 through 2012.

8 “(b) REFERENCES.—Any reference in this title to a
9 provision of this title providing for an authorization of ap-
10 propriation for a fiscal year beginning with fiscal year
11 2008, shall be deemed to be a reference to subsection
12 (a).”.

13 (b) NURSING WORKFORCE DEVELOPMENT PRO-
14 GRAMS.—Part A of title VIII of the Public Health Service
15 Act (42 U.S.C. 296 et seq.) is amended by adding at the
16 end the following:

17 **“SEC. 809. GENERAL AUTHORIZATION OF APPROPRIA-**
18 **TIONS.**

19 “(a) IN GENERAL.—Notwithstanding any other pro-
20 vision of this title, beginning with fiscal year 2008, there
21 is authorized to be appropriated to carry out this title,
22 such sums as may be necessary for each of fiscal years
23 2008 through 2012.

24 “(b) REFERENCES.—Any reference in this title to a
25 provision of this title providing for an authorization of ap-
26 propriation for a fiscal year beginning with fiscal year

1 2008, shall be deemed to be a reference to subsection
2 (a).”.

3 (c) DEVELOPMENT OF METRICS TO MEASURE EF-
4 FECTIVENESS.—

5 (1) HEALTH PROFESSIONS PROGRAMS.—Part F
6 of title VII of the Public Health Service Act (42
7 U.S.C. 295j et seq.), as amended by subsection (a),
8 is further amended by adding at the end the fol-
9 lowing:

10 **“SEC. 799D. DEVELOPMENT OF MEASURES OF EFFECTIVE-**
11 **NESS.**

12 “The Secretary shall develop and publish in the Fed-
13 eral Register measures of effectiveness for each of the pro-
14 grams carried out under this title. The Secretary shall use
15 such measures to annually submit to the Committee on
16 Health, Education, Labor, and Pension of the Senate and
17 the Committee on Energy and Commerce of the House
18 of Representatives a report concerning the effectiveness of
19 such programs.”.

20 (2) NURSING WORKFORCE DEVELOPMENT.—

21 Part A of title VIII of the Public Health Service Act
22 (42 U.S.C. 296 et seq.), as amended by subsection
23 (b), is further amended by adding at the end the fol-
24 lowing:

1 **“SEC. 810. DEVELOPMENT OF MEASURES OF EFFECTIVE-**
2 **NESS.**

3 “The Secretary shall develop and publish in the Fed-
4 eral Register measures of effectiveness for each of the pro-
5 grams carried out under this title. The Secretary shall use
6 such measures to annually submit to the Committee on
7 Health, Education, Labor, and Pension of the Senate and
8 the Committee on Energy and Commerce of the House
9 of Representatives a report concerning the effectiveness of
10 such programs.”.

11 (d) PROVISION OF INFORMATION TO STUDENTS.—
12 Section 726 of the Public Health Service Act (42 U.S.C.
13 292v) is amended by adding at the end the following:

14 “(e) PROVISION OF INFORMATION TO INCOMING STU-
15 DENTS.—Each school shall provide to each student, at the
16 time the school provides such student with a letter of ac-
17 ceptance to attend the school, a statement of the amount
18 of the average aggregate amount of debt incurred by grad-
19 uating students during their period of attendance at the
20 school and the national average for such debt at all schools
21 for the previous year (as determined by the Secretary).”.

22 (e) ENHANCED COMPETITIVENESS.—Section
23 738(b)(2) of the Public Health Service Act (42 U.S.C.
24 293b(b)(2)) is amended—

(1) by striking “that—” and all that follows through “amounts” in subparagraph (A), and inserting “that amounts”;

(2) in subparagraph (A), by striking “; and” and inserting a period; and

(3) by striking subparagraph (B).

SEC. 352. NURSE WORKFORCE ENHANCEMENT.

(a) REAUTHORIZATION OF PRACTICE AND RETENTION GRANT PROGRAM.—Section 831(h) of the Public Health Service Act (42 U.S.C. 296p(h)) is amended by striking “2003 through 2007” and inserting “2008 through 2012”.

(b) STATE DEMONSTRATION PROJECTS TO PROVIDE INCENTIVES FOR NURSES TO REENTER THE WORKFORCE.—Part D of title VIII of the Public Health Service Act (42 U.S.C. 296p et seq.) is amended by adding at the end the following:

“SEC. 832. STATE DEMONSTRATION PROJECTS TO PROVIDE INCENTIVES FOR NURSES TO REENTER THE WORKFORCE.

“(a) IN GENERAL.—The Secretary shall award not to exceed 15 grants to States for the conduct of demonstration projects to evaluate incentives to encourage nurses to reenter the nursing profession at positions in healthcare facilities. For purposes of projects under this

1 section, a nurse shall be deemed to have reentered the
2 workforce if such nurse is licensed and had not practiced
3 nursing for the 3-year period prior to their return to the
4 workforce under a project under this section.

5 “(b) APPLICATION.—To be eligible to receive a grant
6 under subsection (a), a State shall submit to the Secretary
7 an application at such time, in such manner, and con-
8 taining such information as the Secretary may require, in-
9 cluding—

10 “(1) a description of the activities to be con-
11 ducted under the grant, including—

12 “(A) how retraining will be encouraged to
13 update skills;

14 “(B) how license renewal will be encour-
15 aged;

16 “(C) how loan repayment under programs
17 under this title will be monitored;

18 “(D) how healthcare facilities with a crit-
19 ical shortage of nurses will be identified and the
20 shortage will be alleviated by the program;

21 “(E) how the performance of reentry
22 nurses will be monitored and evaluated; and

23 “(F) how part-time positions will be cre-
24 ated to utilize nurses reentering the profession;

1 “(2) an assurance that the State will provide
2 matching funds in accordance with subsection (c);

3 “(3) an assurance that the State will conduct
4 an evaluation in accordance with subsection (d); and

5 “(4) any other assurances required by the Sec-
6 retary.

7 “(c) MATCHING REQUIREMENT.—The Secretary may
8 not make grants to a State under this section unless the
9 State involved agrees, with respect to the costs of carrying
10 out the program under the grant, to make available non-
11 Federal contributions (in cash or in kind) toward such
12 costs in an amount equal to not less than \$1 for each \$1
13 of Federal funds provided under the grant.

14 “(d) EVALUATIONS.—A State that receives a grant
15 under this section shall reserve 5 percent of the amount
16 received under this grant to carry out activities to evaluate
17 the project carried out under the grant. A State shall re-
18 port to the Secretary the results of such evaluation, in-
19 cluding the number of nurses reentering the profession in
20 the State in years prior to the project and the number
21 reentering such profession after the initiation of the
22 project, and the number of such reentering nurses that
23 serve in areas deemed underserved.

24 “(e) AMOUNT AND LENGTH OF GRANTS.—A grant
25 under this section shall not exceed \$2,000,000 for each

1 fiscal year for up to 5 years. Grants may be extended for
2 an additional 5-year period.

3 “(f) DEFINITIONS.—In this section:

4 “(1) HEALTHCARE FACILITY.—The term
5 ‘healthcare facility’ means those facilities that regu-
6 larly dispense healthcare, including hospitals, public
7 health departments, nursing homes, community
8 health centers, rural health clinics, and Indian
9 health service centers.

10 “(2) NURSE.—The term ‘nurse’ includes Reg-
11 istered Nurses.

12 “(3) POSITION.—The term ‘position’ means a
13 full-time or part-time position that includes teaching
14 or delivery of health care to patients.

15 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated such sums as may be nec-
17 essary to carry out this section.”.

18 **SEC. 353. VISAS FOR REGISTERED NURSES.**

19 Paragraph (4) of section 212(m) of the Immigration
20 and Nationality Act (8 U.S.C. 1182(m)) is amended in
21 the matter preceding subparagraph (A) by striking “500”
22 and inserting “600”.

1 **SEC. 354. MEDPAC STUDY AND REPORT ON THE IMPACT OF**
2 **PAYMENT CAPS FOR IME AND GME.**

3 (a) STUDY.—The Medicare Payment Advisory Com-
4 mission shall conduct a study—

5 (1) to analyze the impact that the limitation on
6 the number of residents in allopathic and osteo-
7 pathic medicine under subsections (d)(5)(B)(v) and
8 (h)(4)(F) of section 1886 of the Social Security Act
9 (42 U.S.C. 1395ww) has had with respect to—

10 (A) the national supply of general practi-
11 tioners and specialty healthcare providers;

12 (B) the development of new teaching hos-
13 pitals and medical schools;

14 (C) the ability to support residents in insti-
15 tutions (such as children's hospitals and ad-
16 vanced practice nurse training facilities) that
17 are not eligible for payments for indirect med-
18 ical education costs and direct graduate medical
19 education costs under the Medicare program
20 under title XVIII of the Social Security Act (42
21 U.S.C. 1395 et seq.);

22 (D) the recruitment and retention of
23 healthcare providers in areas designated as
24 health professional shortage areas (as defined
25 in section 332(a)(1) of the Public Health Serv-
26 ice Act) or in areas designated as medically un-

1 derserved areas, with particular focus on States
2 that do not have a medical school located in the
3 State; and

4 (E) the practice of sharing or purchasing
5 residency positions among institutions; and

6 (2) to analyze the payment system for indirect
7 medical education costs and direct graduate medical
8 education costs under the Medicare program under
9 such title with respect to—

10 (A) the accuracy of payments for indirect
11 graduate medical education costs under such
12 system compared with the actual costs incurred
13 by teaching hospitals in providing indirect med-
14 ical education;

15 (B) the range and variance in reimbursable
16 direct graduate medical education costs and the
17 cause of such range and variance; and

18 (C) the commitment of healthcare payers,
19 other than the Medicare program under such
20 title, to reimburse teaching hospitals and other
21 healthcare facilities with qualified medical edu-
22 cation components at increased rates to offset
23 graduate medical education costs that are in-
24 curred in such settings and are not paid under
25 such program.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Medicare Payment Advisory Commission shall submit a report to the Secretary of Health and Human Services and to Congress containing the results of the study conducted under subsection (a), together with such recommendations regarding alternatives and revisions to the payment system for indirect medical education costs and direct graduate medical education costs under the Medicare program under title XVIII of the Social Security Act as the Medicare Payment Advisory Commission determines appropriate.

Subtitle C—Increasing Access to Primary Care

SEC. 361. REAUTHORIZATION OF THE COMMUNITY HEALTH CENTER PROGRAMS.

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

“(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

“(A) \$2,048,670 for fiscal year 2008;

“(B) \$2,110,130 for fiscal year 2009;

“(C) \$2,173,434 for fiscal year 2010;

1 “(D) \$2,244,637 for fiscal year 2011; and

2 “(E) \$2,311,976 for fiscal year 2012.”.

3 (b) MEDICAL RESIDENCY TRAINING PROGRAMS.—

4 Section 330 of the Public Health Service Act (42 U.S.C.
5 254b) is amended—

6 (1) by redesignating subsections (k) through (r)
7 as subsections (l) through (s), respectively; and

8 (2) by inserting after subsection (j), the fol-
9 lowing:

10 “(k) GRANTS TO EXPAND MEDICAL RESIDENCY
11 TRAINING PROGRAMS AT COMMUNITY HEALTH CEN-
12 TERS.—

13 “(1) PROGRAM AUTHORIZED.—The Secretary
14 may make grants to community health centers—

15 “(A) to establish, at the centers, new or al-
16 ternative-campus accredited medical residency
17 training programs affiliated with a hospital or
18 other health care facility; or

19 “(B) to fund new residency positions with-
20 in existing accredited medical residency training
21 programs at the centers and their affiliated
22 partners.

23 “(2) USE OF FUNDS.—Amounts awarded under
24 a grant under this subsection shall be used to cover
25 the costs of establishing or expanding a medical resi-

1 dency training program described in paragraph (1),
2 including costs associated with—

3 “(A) curriculum development;

4 “(B) equipment acquisition;

5 “(C) recruitment, training, and retention
6 of residents and faculty; and

7 “(D) residency stipends.

8 “(3) APPLICATIONS.—A community health cen-
9 ter seeking a grant under this subsection shall sub-
10 mit an application to the Secretary at such time, in
11 such manner, and containing such information as
12 the Secretary may require.

13 “(4) PREFERENCE.—In selecting recipients for
14 a grant under this subsection, the Secretary shall
15 give preference to funding medical residency training
16 programs focusing on primary health care.

17 “(5) DEFINITION.—In this subsection, the term
18 ‘accredited’, as applied to a new or alternative-cam-
19 pus medical residency training program, means a
20 program that is accredited by a recognized body or
21 bodies approved for such purpose by the Accredita-
22 tion Council for Graduate Medical Education, except
23 that a new medical residency training program that,
24 by reason of an insufficient period of operation, is
25 not eligible for accreditation on or before the date of

1 submission of an application under paragraph (3)
 2 shall be deemed accredited if the Accreditation
 3 Council for Graduate Medical Education finds, after
 4 consultation with the appropriate accreditation body
 5 or bodies, that there is reasonable assurance that
 6 the program will meet the accreditation standards of
 7 such body or bodies prior to the date of graduation
 8 of the first entering class in that program.”.

9 **SEC. 362. REAUTHORIZATION OF LOAN REPAYMENT PRO-**
 10 **GRAMS OF THE NATIONAL HEALTH SERVICE**
 11 **CORPS.**

12 (a) IN GENERAL.—Section 338H(a) of the Public
 13 Health Service Act (42 U.S.C. 254q(a)) is amended to
 14 read as follows:

15 “(a) AUTHORIZATION OF APPROPRIATIONS.—For the
 16 purposes of carrying out this subpart, there are authorized
 17 to be appropriated \$129,271,790 for fiscal year 2008,
 18 \$133,150,393 for fiscal year 2009, \$137,145,355 for fis-
 19 cal year 2010, \$141,260,166 for fiscal year 2011, and
 20 \$145,498,421 for fiscal year 2012. Amounts appropriated
 21 under this subsection shall not be used to carry out section
 22 338A.”.

23 (b) STATE LOAN REPAYMENT PROGRAM.—Section
 24 338I(i)(1) of the Public Health Service Act (42 U.S.C.
 25 254q-1(i)(1)) is amended by striking “\$12,000,000” and

1 all that follows through the end and inserting
 2 “\$15,000,000 for each of fiscal years 2008 through
 3 2012.”.

4 **SEC. 363. CLARIFICATION OF AUTHORITY FOR CONVEN-**
 5 **IENT CARE CLINICS TO PARTICIPATE IN MED-**
 6 **ICAID AND SCHIP.**

7 (a) MEDICAID.—

8 (1) STATE PLAN AMENDMENT.—Section
 9 1902(a)(23)(A) of the Social Security Act (42
 10 U.S.C. 1396a(a)(23)(A)) is amended—

11 (A) by inserting “, and a convenient care
 12 clinic, as defined in section 1905(y)” after
 13 “prepayment basis”; and

14 (B) by inserting “(other than with respect
 15 to the ability of an individual to obtain medical
 16 assistance from a convenient care clinic (as so
 17 defined))” after “Guam”.

18 (2) DEFINITION.—Section 1905 of the Social
 19 Security Act (42 U.S.C. 1396d) is amended by add-
 20 ing at the end the following:

21 “(y) For purposes of this title, the term ‘convenient
 22 care clinic’ means a health care facility located in a retail
 23 outlet that provides affordable and accessible, non-emer-
 24 gency health care (as defined by the Secretary) to con-
 25 sumers that is open 7 days a week, for extended hours

1 (as so defined) and is primarily staffed by advanced prac-
 2 tice nurses (including nurse practitioners), as well as by
 3 physician assistants or physicians, who have advanced
 4 education in providing quality health care for common epi-
 5 sodic ailments (as so defined).”.

6 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-
 7 rity Act (42 U.S.C. 1397gg(e)(1)) is amended—

8 (1) by redesignating subparagraphs (B)
 9 through (D) as subparagraphs (C) through (E), re-
 10 spectively; and

11 (2) by inserting after subparagraph (A), the fol-
 12 lowing:

13 “(B) Section 1902(a)(23)(A) (but only
 14 with respect to the ability of an individual to
 15 obtain assistance from a convenient care clinic,
 16 as defined in section 1905(y)).”.

17 (c) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Subject to paragraph (2),
 19 the amendments made by this section take effect on
 20 October 1, 2007.

21 (2) DELAY IF STATE LEGISLATION RE-
 22 QUIRED.—In the case of a State plan under title
 23 XIX or XXI of the Social Security Act or a waiver
 24 of such plan under section 1115 of such Act which
 25 the Secretary of Health and Human Services deter-

1 mines requires State legislation (other than legisla-
2 tion appropriating funds) in order for the plan or
3 waiver to meet the additional requirements imposed
4 by the amendments made by this section, the State
5 plan or waiver shall not be regarded as failing to
6 comply with the requirements of such title solely on
7 the basis of its failure to meet such additional re-
8 quirements before the first day of the first calendar
9 quarter beginning after the close of the first regular
10 session of the State legislature that begins after the
11 date of the enactment of this Act. For purposes of
12 the previous sentence, in the case of a State that has
13 a 2-year legislative session, each year of such session
14 shall be deemed to be a separate regular session of
15 the State legislature.

16 **Subtitle D—Rural Health Care**

17 **SEC. 371. REAUTHORIZATION OF RURAL HEALTH CARE PRO-** 18 **GRAMS.**

19 Section 330A(j) of the Public Health Service Act (42
20 U.S.C. 254c(j)) is amended by striking “\$40,000,000”
21 and all that follows and inserting “\$45,000,000 for each
22 of fiscal years 2008 through 2010.”.

1 **Subtitle E—Long Term Care**

2 **SEC. 381. SENSE OF THE SENATE.**

3 It is the Sense of the Senate that all Americans
4 should establish an advance directive.

5 **SEC. 382. LIVING WILLS.**

6 The Secretary of Health and Human Service shall
7 provide for the development of an Internet website (at
8 www.livingwill.gov) to provide all Americans with access
9 to information on advance directives and a website on
10 which to store and access such directives.

11 **SEC. 383. INCREASING SENIOR CHOICE AND ACCESS TO** 12 **COMMUNITY-BASED LONG TERM CARE.**

13 Part P of title III of the Public Health Service Act
14 (42 U.S.C. 280g et seq.) is amended by adding at the end
15 the following:

16 **“SEC. 399R. INCREASING SENIOR CHOICE AND ACCESS TO** 17 **COMMUNITY-BASED LONG TERM CARE.**

18 “(a) IN GENERAL.—The Secretary may award one-
19 time grants to eligible entities, as defined by the Sec-
20 retary, for the conduct of demonstration projects to plan
21 and develop the entity’s transitions from institutional set-
22 tings of skilled nursing care to residential or community-
23 based settings of integrated skilled nursing care, which
24 shall include—

1 “(1) the provision of housing units and staff
2 meeting all Federal and State qualifications and li-
3 censure requirements, as applicable to the level of
4 care to be provided;

5 “(2) eligibility and qualification assistance for
6 reimbursement under applicable State Medicaid pro-
7 grams;

8 “(3) the provision of a residential or home envi-
9 ronment which encourages independent living, pri-
10 vacy, and community engagement;

11 “(4) encouraging a sense of community by hav-
12 ing a number of low-occupancy housing units ar-
13 ranged with similarly structured housing units spe-
14 cializing in long term care;

15 “(5) an emphasis on building relationships be-
16 tween care providers and clients by encouraging
17 teams to remain with a set of patients throughout
18 their stay;

19 “(6) the direct involvement by the clients in de-
20 veloping activities and structuring care needs; and

21 “(7) the formation of an integrated, self-man-
22 aged clinical and personal care team, including
23 healthcare providers, specialists and appropriate per-
24 sonnel, available to the community as needed.

1 “(b) APPLICATION.—An eligible entity desiring a
2 grant under this section shall submit an application to the
3 Secretary at such time, in such manner, and containing
4 such information as the Secretary may reasonably require.

5 “(c) REPORT.—Not later than 3 years after the date
6 on which the first grant is awarded under this section,
7 the Secretary shall submit to the appropriate committees
8 of Congress a report concerning the efficacy of the model
9 carried out under this section in improving quality of life
10 indicators, employee satisfaction, and clinical outcomes.

11 “(d) PRIORITY.—In making grants under this sec-
12 tion, the Secretary shall give priority to entities providing
13 services to a medically underserved area.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of awarding grants under this section, there is
16 authorized to be appropriated \$5,000,000 for each of fis-
17 cal years 2008 through 2013.”.

18 **Subtitle F—Fair and Reliable**
19 **Medical Justice**

20 **SEC. 391. SHORT TITLE.**

21 This subtitle may be cited as the “Fair and Reliable
22 Medical Justice Act”.

23 **SEC. 392. PURPOSES.**

24 The purposes of this subtitle are—

(1) to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors;

(2) to promote patient safety through disclosure of health care errors; and

(3) to support and assist States in developing such alternatives.

SEC. 393. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

“SEC. 399R. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

“(a) IN GENERAL.—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care

1 organizations. In awarding such grants, the Secretary
2 shall ensure the diversity of the alternatives so funded.

3 “(b) DURATION.—The Secretary may award up to 10
4 grants under subsection (a) and each grant awarded under
5 such subsection may not exceed a period of 5 years.

6 “(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

7 “(1) REQUIREMENTS.—Each State desiring a
8 grant under subsection (a) shall—

9 “(A) develop an alternative to current tort
10 litigation for resolving disputes over injuries al-
11 legedly caused by health care providers or
12 health care organizations; and

13 “(B) promote a reduction of health care
14 errors by allowing for patient safety data re-
15 lated to disputes resolved under subparagraph
16 (A) to be collected and analyzed by organiza-
17 tions that engage in efforts to improve patient
18 safety and the quality of health care.

19 “(2) ALTERNATIVE TO CURRENT TORT LITIGA-
20 TION.—Each State desiring a grant under sub-
21 section (a) shall demonstrate how the proposed al-
22 ternative described in paragraph (1)(A)—

23 “(A) makes the medical liability system
24 more reliable through prompt and fair resolu-
25 tion of disputes;

“(B) encourages the disclosure of health care errors;

“(C) enhances patient safety by detecting, analyzing, and reducing medical errors and adverse events;

“(D) maintains access to liability insurance; and

“(E) provides patients the opportunity to opt out of or voluntarily withdraw from participating in the alternative.

“(3) SOURCES OF COMPENSATION.—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

“(4) SCOPE.—

“(A) IN GENERAL.—Each State desiring a grant under subsection (a) may establish a scope of jurisdiction (such as a designated geographic region, a designated area of health care practice, or a designated group of health care

1 providers or health care organizations) for the
2 proposed alternative to current tort litigation
3 that is sufficient to evaluate the effects of the
4 alternative.

5 “(B) NOTIFICATION OF PATIENTS.—A
6 State proposing a scope of jurisdiction under
7 subparagraph (A) shall demonstrate how pa-
8 tients would be notified that they are receiving
9 health care services that fall within such scope,
10 and that they may opt out of or voluntarily
11 withdraw from participating in the alternative.

12 “(5) PREFERENCE IN AWARDING DEMONSTRA-
13 TION GRANTS.—In awarding grants under sub-
14 section (a), the Secretary shall give preference to
15 States—

16 “(A) that have developed the proposed al-
17 ternative through substantive consultation with
18 relevant stakeholders, including patient advo-
19 cates, health care providers and health care or-
20 ganizations, attorneys with expertise in rep-
21 resenting patients and health care providers,
22 medical malpractice insurers, and patient safety
23 experts;

24 “(B) that make proposals that are likely to
25 enhance patient safety by detecting, analyzing,

1 and reducing medical errors and adverse events;
2 and

3 “(C) in which State law at the time of the
4 application would not prohibit the adoption of
5 an alternative to current tort litigation.

6 “(d) APPLICATION.—

7 “(1) IN GENERAL.—Each State desiring a
8 grant under subsection (a) shall submit to the Sec-
9 retary an application, at such time, in such manner,
10 and containing such information as the Secretary
11 may require.

12 “(2) REVIEW PANEL.—

13 “(A) IN GENERAL.—In reviewing applica-
14 tions under paragraph (1), the Secretary shall
15 consult with a review panel composed of rel-
16 evant experts appointed by the Comptroller
17 General.

18 “(B) COMPOSITION.—

19 “(i) NOMINATIONS.—The Comptroller
20 General shall solicit nominations from the
21 public for individuals to serve on the re-
22 view panel.

23 “(ii) APPOINTMENT.—The Comp-
24 troller General shall appoint, at least 14
25 but not more than 19, highly qualified and

1 knowledgeable individuals to serve on the
2 review panel and shall ensure that the fol-
3 lowing entities receive fair representation
4 on such panel:

5 “(I) Patient advocates.

6 “(II) Health care providers and
7 health care organizations.

8 “(III) Attorneys with expertise in
9 representing patients and health care
10 providers.

11 “(IV) Medical malpractice insur-
12 ers.

13 “(V) State officials.

14 “(VI) Patient safety experts.

15 “(C) CHAIRPERSON.—The Comptroller
16 General, or an individual within the Govern-
17 ment Accountability Office designated by the
18 Comptroller General, shall be the chairperson of
19 the review panel.

20 “(D) AVAILABILITY OF INFORMATION.—
21 The Comptroller General shall make available
22 to the review panel such information, personnel,
23 and administrative services and assistance as
24 the review panel may reasonably require to
25 carry out its duties.

1 “(E) INFORMATION FROM AGENCIES.—The
2 review panel may request directly from any de-
3 partment or agency of the United States any
4 information that such panel considers necessary
5 to carry out its duties. To the extent consistent
6 with applicable laws and regulations, the head
7 of such department or agency shall furnish the
8 requested information to the review panel.

9 “(e) REPORTS.—

10 “(1) BY STATE.—Each State receiving a grant
11 under subsection (a) shall submit to the Secretary
12 an annual report evaluating the effectiveness of ac-
13 tivities funded with grants awarded under such sub-
14 section.

15 “(2) BY SECRETARY.—The Secretary shall sub-
16 mit to Congress an annual compendium of the re-
17 ports submitted under paragraph (1).

18 “(f) TECHNICAL ASSISTANCE.—

19 “(1) IN GENERAL.—The Secretary shall provide
20 technical assistance to the States applying for or
21 awarded grants under subsection (a).

22 “(2) REQUIREMENTS.—Technical assistance
23 under paragraph (1) shall include—

24 “(A) guidance on non-economic damages,
25 including the consideration of individual facts

1 and circumstances in determining appropriate
2 payment, guidance on identifying avoidable in-
3 juries, and guidance on disclosure to patients of
4 health care errors and adverse events; and

5 “(B) the development, in consultation with
6 States, of common definitions, formats, and
7 data collection infrastructure for States receiv-
8 ing grants under this section to use in reporting
9 to facilitate aggregation and analysis of data
10 both within and between States.

11 “(3) USE OF COMMON DEFINITIONS, FORMATS,
12 AND DATA COLLECTION INFRASTRUCTURE.—States
13 not receiving grants under this section may also use
14 the common definitions, formats, and data collection
15 infrastructure developed under paragraph (2)(B).

16 “(g) EVALUATION.—

17 “(1) IN GENERAL.—The Secretary, in consulta-
18 tion with the review panel established under sub-
19 section (d)(2), shall enter into a contract with an ap-
20 propriate research organization to conduct an overall
21 evaluation of the effectiveness of grants awarded
22 under subsection (a) and to annually prepare and
23 submit a report to Congress. Such an evaluation
24 shall begin not later than 18 months following the

1 date of implementation of the first program funded
2 by a grant under subsection (a).

3 “(2) CONTENTS.—The evaluation under para-
4 graph (1) shall include—

5 “(A) an analysis of the effects of the
6 grants awarded under subsection (a) on the
7 measures described in paragraph (3);

8 “(B) a comparison between and among the
9 alternatives approved under subsection (a) of
10 the measures described in paragraph (3); and

11 “(C) a comparison between and among
12 States receiving grants approved under sub-
13 section (a) and similar States not receiving
14 such grants of the measures described in para-
15 graph (3).

16 “(3) MEASURES.—The evaluations under para-
17 graph (2) shall analyze and make comparisons on
18 the basis of—

19 “(A) the nature and number of disputes
20 over injuries allegedly caused by health care
21 providers or health care organizations;

22 “(B) the nature and number of claims in
23 which tort litigation was pursued despite the ex-
24 istence of an alternative under subsection (a);

1 “(C) the disposition of disputes and claims
2 described in clauses (i) and (ii), including the
3 length of time and estimated costs to all par-
4 ties;

5 “(D) the medical liability environment;

6 “(E) health care quality;

7 “(F) patient safety in terms of detecting,
8 analyzing, and reducing medical errors and ad-
9 verse events; and

10 “(G) patient and health care provider and
11 organization satisfaction with the alternative
12 under subsection (a) and with the medical li-
13 ability environment.

14 “(4) FUNDING.—The Secretary shall reserve 5
15 percent of the amount appropriated in each fiscal
16 year under subsection (j) to carry out this sub-
17 section.

18 “(h) OPTION TO PROVIDE FOR INITIAL PLANNING
19 GRANTS.—Of the funds appropriated pursuant to sub-
20 section (j), the Secretary may use a portion not to exceed
21 \$500,000 per State to provide planning grants to such
22 States for the development of demonstration project appli-
23 cations meeting the criteria described in subsection (c).
24 In selecting States to receive such planning grants, the
25 Secretary shall give preference to those States in which

1 State law at the time of the application would not prohibit
 2 the adoption of an alternative to current tort litigation.

3 “(i) DEFINITIONS.—In this section:

4 “(1) HEALTH CARE SERVICES.—The term
 5 ‘health care services’ means any services provided by
 6 a health care provider, or by any individual working
 7 under the supervision of a health care provider, that
 8 relate to—

9 “(A) the diagnosis, prevention, or treat-
 10 ment of any human disease or impairment; or

11 “(B) the assessment of the health of
 12 human beings.

13 “(2) HEALTH CARE ORGANIZATION.—The term
 14 ‘health care organization’ means any individual or
 15 entity which is obligated to provide, pay for, or ad-
 16 minister health benefits under any health plan.

17 “(3) HEALTH CARE PROVIDER.—The term
 18 ‘health care provider’ means any individual or enti-
 19 ty—

20 “(A) licensed, registered, or certified under
 21 Federal or State laws or regulations to provide
 22 health care services; or

23 “(B) required to be so licensed, registered,
 24 or certified but that is exempted by other stat-
 25 ute or regulation.

1 “(4) NET ECONOMIC LOSS.—The term ‘net eco-
2 nomic loss’ means—

3 “(A) reasonable expenses incurred for
4 products, services, and accommodations needed
5 for health care, training, and other remedial
6 treatment and care of an injured individual;

7 “(B) reasonable and appropriate expenses
8 for rehabilitation treatment and occupational
9 training;

10 “(C) 100 percent of the loss of income
11 from work that an injured individual would
12 have performed if not injured, reduced by any
13 income from substitute work actually per-
14 formed; and

15 “(D) reasonable expenses incurred in ob-
16 taining ordinary and necessary services to re-
17 place services an injured individual would have
18 performed for the benefit of the individual or
19 the family of such individual if the individual
20 had not been injured.

21 “(5) NON-ECONOMIC DAMAGES.—The term
22 ‘non-economic damages’ means losses for physical
23 and emotional pain, suffering, inconvenience, phys-
24 ical impairment, mental anguish, disfigurement, loss
25 of enjoyment of life, loss of society and companion-

1 ship, loss of consortium (other than loss of domestic
2 service), injury to reputation, and all other non-pe-
3 cuniary losses of any kind or nature, to the extent
4 permitted under State law.

5 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section
7 such sums as may be necessary. Amounts appropriated
8 pursuant to this subsection shall remain available until ex-
9 pended.”.



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